PUBLIC HEALTH NURSING

DECEMBER
1946

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CONTENTS

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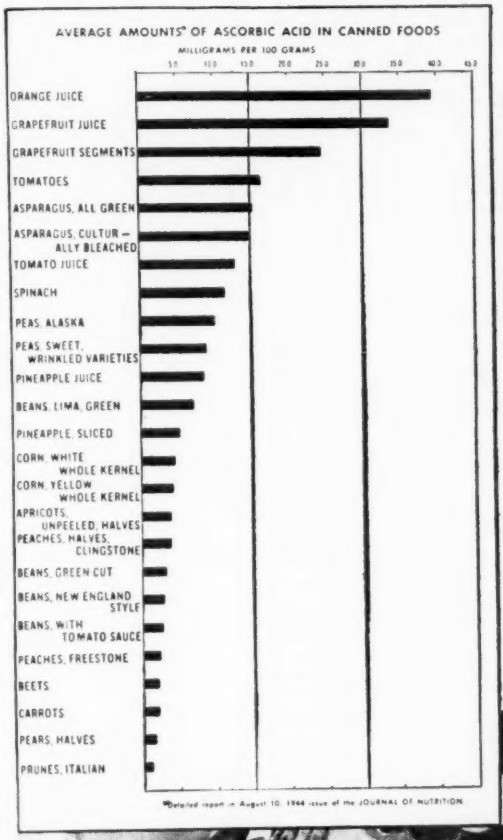

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Not just another chart, the chart on the left—and each chart in this series—presents *net* values, actual on-the-table values in foods packed in cans. Therefore, their significance is plain. As you know, the figures usually quoted in nutrition tables are *gross* figures for raw, *uncooked* foods which do not take into consideration losses which occur in transit from field to market, to kitchen, *and* in home preparation.

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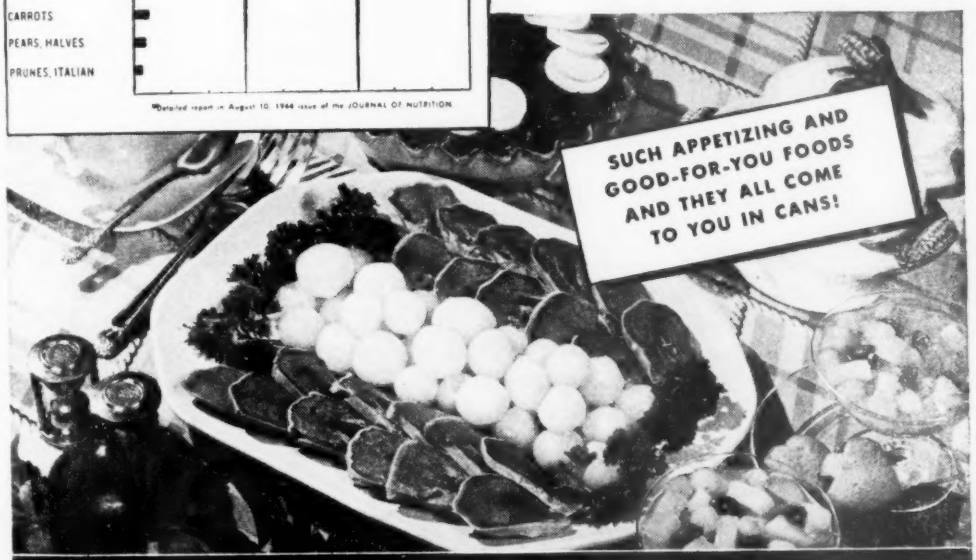

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

CHRISTMAS — 1946

LEGEND

What shall we say of that enduring story
That does not die although the years rush on?
It is not vague, it is not transitory,
And centuries have gone.

It is like deathless bronze that will not perish,
It is as new—and old—as the sweet spring.
Why is it that its beauty and grace we cherish,
And to its wonder cling?

A Star, some shepherds, and a Mother holy,
A Child within a manger with the kine;
Gifts from the Magi brought to portals lowly,
Richer than richest wine.

The tale endures, and all the words of sages
Repeat the solemn message down the years,
And man has heard it through the echoing ages,
With smiles akin to tears.

It must be true—this legend—like the roses,
Each coming back upon its deathless stem.
Ah! thus it lasts, as Time's book never closes,
Sweet tale of Bethlehem!

— CHARLES HANSON TOWNE

A STAR—a tale—a carol—a fir tree tall—a vivid holly spray—a candle burning brightly—these and many other symbols mean December and the close of a year. They mean Christmas and the dawning of fresh hope as the hearts of men are warmed about the fires of friendship and good cheer. And in those fires, as in the eyes of the group about them, one sees the eternal hope of the world—men of good will whose glory is their faith in mankind.

We in public health nursing catch that gleam throughout the year—not alone at one season. For us it is recurrently present in the faces of our patients—a young mother with her firstborn, a child who laughing takes his first step, a father proudly bringing his twins to school, a grandmother spanning two generations with her love for a great-grandchild. For us, each day in the year holds the living fragments of a more perfect society. It often holds

as well the broken pieces of a shattered society, but at this season hope springs high and we press forward with glad determination.

Each of us interprets the season of the Star in her own way, but each resolves anew to play her small part in mankind's long journey toward healthful, happy living with greater devotion. We know the equipment we shall need —knowledge, skill, tolerance, perseverance, patience, understanding, kindness, and above all a twinkle in our eyes. We know the road we travel and that we never walk alone. Let us then step forward firmly, fearlessly, joyfully together —for together we have the task to do and together we shall succeed.

RUTH W. HUBBARD, PRESIDENT
NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

No Drugs Yet for TB

IN MAN'S survey of substances for use against tuberculosis almost innumerable drugs have been tried. Prior to five years ago, every one of them was a flat failure and every one has gone into the limbo of forgotten things. However, work with various sulfa drugs in different parts of the country showed some promise and, for the first time, it appeared that we might really begin to hope that a drug cure for tuberculosis could be found.

When tuberculous guinea pigs were treated with these drugs, the progress of the disease was modified. The diseased area was smaller than had been expected and regressed or scarred in nature. Some of the drugs prevented the disease from developing as long as the drug was given, but the tuberculosis progressed and killed as soon as the drug was withheld. These drugs are altogether too toxic to be continued in man for a long period. Besides, they do not produce the favorable effect on human tuberculosis that they do in animals.

The coming of streptomycin has been an interesting and promising development because it appears to modify—but cannot cure—tuberculosis favorably. This drug is under study in several places throughout the country, notably at the Mayo Clinic, Rochester, Minn.; the Saranac Laboratory, Saranac Lake, N. Y.; and the National Institute of Health, Bethesda, Md. From the studies so far made on animals, streptomycin appears to give considerable protection against tuberculosis—not complete, but more than any other drug has ever given. It is not, however, a cure.

Streptomycin has been used in the treatment of several people with tuberculosis, most of whom have been helped. But the disease returns to its former state when streptomycin is withdrawn. No one has been cured by streptomycin and no proof exists that anyone will be cured. Active study of the drug by chemists and physicians proceeds in the hope that sooner or later a substance related to streptomycin will be found which will really cure.

At present, streptomycin stands out as a landmark on the road toward a cure. It is a remarkable drug which is receiving exacting care. Until the proper substance is found, however, we should continue to use all the accepted methods of treatment which, in so many cases, do great good.

(Continued on page 666)

Community Nursing—The Challenge of Nursing Education

By ELIN L. ANDERSON

IN DISCUSSING Miss Petry's prophetic paper on the future of nursing,* I wish first to define my limitations. I am not a nurse. My only knowledge of the complex problems faced by the nursing profession has been gleaned during several years' experience with the Farm Foundation of Chicago and more recently with the Extension Service of the United States Department of Agriculture in an educational and organization program to help rural people improve their health and medical services. At that, my knowledge is very limited because my major attention has been focused on the most pressing problems facing rural people which have been securing doctors, planning for hospitals, paying for medical care. I accepted participating in this discussion mainly because of the opportunity it provided for learning more about the problems of community nursing services and nursing education. The only thing I am prepared to do is to make some informal observations—and these based mainly on experience in working with rural people.

The average consumer of nursing service, certainly the rural consumer, is little aware of the self-analysis going on among nurses about the future of their profession. The consumer's major concern is getting a nurse when he needs one. And what a problem he finds that to be! He may live in a community which has a school nurse or industrial nurse, but he knows that he cannot expect her to help him when he is sick. He may be fortunate enough to live where there is a visiting nurse association, but he hesitates to call on its services lest he give the erroneous impression to his neighbors that he is accepting essentially a charity service. He may even be able to point with pride to the nurses from the local public health department who go about in pleasing blue uniforms organizing well-baby conferences, immunization clinics, and health examinations in the schools. He knows, however, that although he helps pay for their services through his taxes he cannot ask them to give bedside care, due frequently to something called "agency policy."

Hence, if he is seriously ill, whether at home or in the hospital, and needs a special duty nurse, he is first confronted with the difficult problem of finding such a person, and second, with the pocketbook-breaking cost of her service. Frequently he settles for relatives taking turn in caring for him or for a self-trained practical nurse in hope that such substitutes will do, irrespective of the seriousness of the illness and the need for more professional care.

If he is ill in a hospital he soon discovers that the nurses are handicapped in giving the best care, that they are overworked, underpaid, and often low in morale. He may vow that as soon as he gets out he will do everything he can to gain more adequate community support of the hospital and of all community nursing service.

When he gets well, however, he finds he does not know where to begin, and lacking technical guidance, reluctantly decides that perhaps nothing can be done. This we label public apathy.

Miss Anderson is Extension Specialist in Rural Health Services, Extension Service, United States Department of Agriculture. The opinions expressed in this article are those of the writer, and do not represent the official views of the Department of Agriculture.

*"Community Nursing—The Challenge of Nursing Education," by Lucile Petry, R.N., was published in the November 1946 *American Journal of Nursing*.

THERE ARE many reasons for seeming public apathy about planning for and supporting an adequate community nursing service. One important reason, at least on the part of many rural people, is the lack of experience with any type of nursing service. It is well to remember that nurses, like doctors and dentists, have for years concentrated in the large urban centers, so that by 1941, for example, while Connecticut enjoyed the ratio of one active nurse to every 336 persons, Mississippi had only one nurse for every 2,143 persons.

It is well to remember that there are still 1,200 rural counties in the United States with no recognized hospital within their borders, and that these counties have a total population of fifteen million people. It is well to remember that there are still 1,400 counties without local public health services, and although there may be nurses in a number of these counties, their services are so thinly spread that it is difficult for the public to envision the contribution that they might make if given a real opportunity.

And it is well to remember that recent studies of available nursing personnel make a gloomy prognosis of the length of time it will take to have a comprehensive community nursing service fairly equally distributed over this land. These factors must enter into any broad planning for community nursing services.

Even in the thickly populated areas where people have had experience with nursing services, there is often a discouraging lack of public concern to secure an adequate nursing program. Again, this is due to many factors, but one of the most important is the lack of public understanding of what an adequate nursing service might be and how it might be obtained.

Some of the conflicts within the nursing profession are mirrored in the confusion of the consumer. He is aware of a wide gap between the nurses who nurse and those who are primarily health teachers; between the low annual income of nurses and the high daily cost they are to him when he is sick. Before he can merge these conflicting factors into a constructive plan for an integrated nursing service he needs technical advice and guidance.

This technical guidance is now available from the nursing profession. The over-all requirements for providing a comprehensive nursing service have been outlined in "A Comprehensive Program for Nation-wide Action in the Field of Nursing."* This is a milestone in the coordination of effort of the major national organizations to provide the leadership in planning for and building an adequate nursing service for every community. A first follow-up of the recommendations of this program has been the survey made in Michigan of all nursing resources in the state as well as the resources for the preparation of nurses. Such an inventory is needed in every state.

NO PLANNING for a comprehensive nursing service is enough, however, without consideration of methods of paying for such a service. That is what the consumer wants to know—what price good nursing care! As Miss Petry has pointed out, the method of paying for nursing care, as well as for all other health care, may be the focal point on which major reorganization and reorientation of the nursing and all health services of any community will take place. Again, the nursing profession has taken leadership in exploring this important issue through its recent study of nursing services provided in some twenty-seven prepayment plans. This study has raised the question, however, whether nurses should seek to have their services included in some existing prepayment plans for hospital or medical care, and especially whether they should attempt to set up any such plans for their own services. They are discouraged from doing this due to the serious shortage of nurses and the advice of other professional groups to wait until hospital and medical service plans are better developed. More reasons can always be found for not starting a project than for starting it. It may be well to bear in mind that if hospitals and physicians had waited to have adequate facilities and personnel before offering hospital and medical insurance plans to the public there would be few such plans in existence today.

If the nursing profession is going to fulfill its rightful role in any coming comprehensive national health program, under whatever auspices that may be developed, it would seem crucial that nurses explore ways and means

*This "blueprint of nursing," published in the September 1945 *American Journal of Nursing*, is available in reprint form from the National Nursing Council, 1790 Broadway, New York 19, N. Y.

by which they can best function in such a service, while the pattern for it is being molded through the efforts of both volunteer and public agencies. The most important way of determining their place in such a program is to set up demonstrations and experiments in prepaid personal nursing care which can be evaluated in establishing nursing policies in a comprehensive personal health service.

I have often wondered why the pattern of nursing service developed in Brattleboro, Vermont, has not been followed in more communities. The Brattleboro plan does two important things: first, it arranges for the training and supervision of practical nurses by professional nurses, and then provides an insurance plan by which families may be assured of nursing care, either practical or professional, part-time or full-time, according to the needs of the case rather than according to the ability of the family to pay for the service. In such manner does a community develop an appreciation of an integrated community nursing service.

IMPORTANT as it is for nurses to seek to have their services included in existing health insurance plans or to set up new ones of their own in order to fulfill effectively their professional role, it is still more important that they do so because of the contribution they have to offer to the administration and interpretation of these plans. *Nurses are the only professional group which has had long experience in effective community organization for personal health services in the home.*

When the demands for nursing service have far exceeded the nursing resources, public health nurses especially have learned how to select cases according to the greatest need. They have learned how to relieve physicians of many unnecessary calls and thereby free them for more important tasks. On the basis of this experience, they have much to offer to the administration of any prepaid medical or hospital plans, to assure the best use not only of nursing, but also of physicians' services. Then, too, because of their intimate and frequent contacts with families in their homes, nurses are in a key position to interpret a prepaid medical plan to the people, and the people's needs to the medical plan.

An even greater responsibility rests with the hospital and private duty nurses to have their services included in prepaid medical plans. Only by so doing will they discover ways by which their services can be effectively coordinated, their annual incomes considerably increased, and the services that they can offer to the consumer greatly augmented. For all these and many other reasons, one cannot urge too strongly, that all nurses come to grips with the problem of including nursing services in personal health service plans whether they be local, state, or national in scope.

As Miss Petry has envisioned, the future of the nursing profession is a challenging one—changes due to scientific inventions bringing changes in types of nursing services needed; changes in organization of medical services bringing changes in the proportion of home and clinical nursing care; changes in cooperative arrangements between physicians and nurses, and between nurses and nurse's aides, visiting housekeepers, technical specialists of various kinds; changes in methods of paying for nursing services; changes in consumer participation in developing adequate community nursing service.

Such changes in community nursing service are a challenge to nursing education. Nursing offers an opportunity to people with talents ranging from those involved in the great art of caring for the sick to those called for in the complex task of community organization to prevent disease and to promote health. Thus, nursing encompasses many of the arts and sciences needed to heal a broken body and those needed to heal a broken world. Training for such a profession must include deep appreciation of the behavior of the mind and body in sickness and in health, as well as the effective organization and financing of all community health services to safeguard the health and well-being of the citizens.

Planning and organizing, as well as recruiting and training nurses for such a comprehensive community nursing service is a monumental task. It cannot be done by the nursing profession alone. It can only be done by the cooperative effort of all groups concerned. To the principle of such cooperative effort, all professional groups subscribe. But there is often hesitancy about putting this principle into practice due to some fear that laymen participating in either planning, organizing, or administering health services will intrude

on the rightful sphere of the professional groups. Yet these groups must know that only through joint planning can mutual trust be established and the respective responsibilities of lay and professional groups to the development of any health service be fully understood and duly respected.

Certainly, it is well for professional groups to bear in mind that the consumer who receives the service, foots the bill, and whose health is at stake has basic responsibility for determining what kind of health service he wants, and how he shall pay for it. He has basic responsibility for participating in the organization and administration of such services.

Nurses appreciate the necessity of cooperation with all groups concerned in the development of any adequate health service. But I am stating this fundamental principle of cooperation with consumer groups lest there be any nursing associations, local, state, or national, which may want to hug close to themselves all plans and programs for community nursing services. *To any such groups, I must plead that only as they share with the people their present problems and their future goals, and render unto the people the responsibilities that belong to the people, will the nursing profession be free to enhance its cherished leadership and strengthen its professional status.*

With this principle of cooperation in mind, the major question is, "How shall nurses proceed to give leadership in their own communities to secure comprehensive community nursing service?" Let me first recommend as an invaluable guide, the little leaflet prepared by the Joint Committee on Community Nursing Service entitled "Guide to Organizing a Community Group Interested in Nursing Services."* Other than that I can here make only a few suggestions.

The first step for any community to take is to analyze its nursing needs; next, plan immediate and long-time goals for the achievement of an adequate nursing service; and then organize the community resources to meet the most pressing needs. The outstanding accomplishments of a number of community nursing councils stand as invaluable demonstrations of the steps any community may take toward attaining a comprehensive nursing service. Such community nursing councils cannot be too highly commended.

The procedure for developing a nursing service may differ somewhat, however, between urban and rural areas. In urban centers, the area to be served may be clearly defined by the city limits; in rural areas a community may be a county seat, a part of a county, or a whole group of counties.

A full appreciation of *natural neighborhoods* is essential to any successful rural community organization for nursing service. Then, too, in urban centers nursing councils composed of representatives of one group of people to help plan and organize a service for another and less privileged group seems to work out very satisfactorily. In many rural areas, this type of organization may prove inadvisable. Rural pride and independence would necessitate that a community service, to be successful, would have to be planned and organized for the people by the people who would use the service.

Local planning for nursing services, however, is not enough. It is too little and too late for such planning alone. What is needed now is integrated planning of local, state, and national groups. Nurses might well take a leaf from the procedure followed by the state and national organizations which have done such effective planning for public health units and hospital districts over the entire nation.

It might be worth considering what could be accomplished if a broadly representative group of all concerned in every state were to analyze, with technical guidance, all types of nursing resources including those for training of nurses, and measure these by approved, desirable standards for adequate nursing service. Maps comparing the present situation with desirable standards, prepared somewhat in line with proposed public health units or hospital districts, might well provide the public with the first effective guide for developing a comprehensive nursing service. Then, if in addition to such a guide, plans and proposals for, and demonstrations of successful financing of such a nursing service were presented, it would not be long before people of every community shook off their seeming apathy and took the first steps toward providing themselves with adequate nursing care.

(Continued on page 648)

*Available in reprint form from the National Organization for Public Health Nursing, 1790 Broadway, New York 19, N. Y.

The Obstetrician Looks at Maternity Nursing

By NICHOLSON J. EASTMAN, M.D.

IT IS THE MAIN purpose of this paper to affirm (1) that there is urgent need for the services of advanced maternity nurses both by the physicians and the mothers of this country and (2) that it should be the high objective of this group to delineate clearly the field of advanced maternity nursing, to enumerate its objectives, and to show that the field of the advanced maternity nurse and that of the obstetrician do not overlap but subserve each other to the best interests of the patient.

Since I use the term "advanced maternity nursing" rather than "nurse-midwifery," some words of explanation are in order. I like the derivation of the term midwife from the Middle English, "mid" meaning "with," and "wif" meaning "woman": the "with-woman," the woman who stays *with* the parturient throughout her ordeals and by implication the woman who feels *with* the mother throughout pregnancy, labor, and the puerperium. I like the fine traditions of European midwifery with its Trotulas and La Chapelles; and I admire the accomplishments of the splendid Scandinavian school of midwives. However, in the United States, midwifery has been sort of a renegade orphan. Because no special effort was made to train and supervise midwives until very recent years, a widespread but rather surreptitious type of midwifery came to be developed by women who had learned what little they knew as girl apprentices to older midwives. It was only natural that obstetricians should inveigh against these uneducated, untrained, and unclean practitioners and everyone here will agree that they are a menace to maternity. For the purpose of our present discussion, the sordid record of these American Sairey Gamps is an important consideration because it does color and will continue to color the minds of most obstetricians whenever the word "midwifery" is mentioned. Accordingly, the average physician is likely to look askance on any person who calls herself "midwife," be her training and competence ever so superior. This difficulty, of course, is obviously due to a misunderstanding as to what a nurse-midwife actually is and could doubtless be corrected in time by education; but it seems to me that this educational process could be made much simpler if some such term as "advanced maternity nurse" or the briefer "maternity nurse" were employed.

A second reason for my preferring the term "advanced maternity nursing" is the fact that the horizons which I envision as belonging to this field are much broader than the word "nurse-midwifery" connotes,—at least to my ear. Such a nurse should be as competent to supervise a labor floor in a large metropolitan hospital as she is to conduct an aseptic delivery in the meanest hovel; as able to organize a prenatal clinic in a university hospital as to conduct mothers' classes in the Ozarks. Actually, the nurse-midwives whom I know are competent to do all this, but to the uninitiated the name they go by will suggest, I fear, that their chief stock in trade is simply the delivery of babies. As I see it, this is but one of a dozen skills which these maternity nurses must possess.

MORE IMPORTANT than the matter of name, however, are the objectives of advanced maternity nursing. In what fields can these nurses make the greatest contribution to the welfare of motherhood? Owing to time limitations I shall have to confine my discussion to one field. This has been chosen because (1) it is of transcendant importance (2) it has heretofore been almost completely neglected and (3) it is a field which can be developed only by advanced maternity nurses. I refer to the mental hygiene of pregnancy.

There can be no doubt that the contributions of obstetricians to the saving of maternal

Dr. Eastman is professor of Obstetrics, Johns Hopkins University, Baltimore, Maryland.

and infant life have been monumental, but they have been almost entirely on the physical side. Human pregnancy is not only a physical, biologic event; it is a stirring emotional and psychologic experience. The physical hygiene and management of pregnancy, labor, and the puerperium have been developed to a high degree, but its mental hygiene has been well nigh overlooked.

As the first desideratum under the mental hygiene of pregnancy, I would place the elimination of fear. "In sorrow thou shalt bring forth children," reads Genesis iii: 16; "Now will I cry like a travailing woman," Isaiah xlii: 14; "They shall be in pain as a woman that travaileth," Isaiah xiii: 8. Many other passages in the Bible convey the same impression: misery, pain, and sorrow. These old warnings, augmented by whispered stories from friends and even mothers of disaster and actual death in childbirth, have so branded themselves on the minds of countless millions of young girls that labor looms before them as the very epitome of unmitigated agony. Many of them live with fear for nine long months.

As the result of the studies of Cannon and other physiologists, it is now known that fear exerts widespread effects on bodily function. In this connection Grantly Dick Read, an eminent London obstetrician, has long held that "fear is the arch enemy of motherhood." He cites not only clinical but neurologic evidence to show that fear causes contraction of certain circular fibers of the lower uterine segment which oppose cervical dilatation and descent of the baby. Hence, according to his belief, fear causes labors to be longer and more painful. "A tense woman means a tense cervix," Read writes. And certainly no obstetrician of experience would gainsay the validity of that observation. In other words, quite apart from the mental turmoil and even marital unhappiness which fear of labor causes, there is evidence to indicate that it has an important bearing on the mechanism of parturition itself.

BUT HOW CAN fear be eliminated? Most certainly, it will not be eliminated by the assembly-line technic of most of our antepartal clinics where, after an endless wait on a long bench, the patient finally progresses from window to window, and from room to room, at each of which one or another item is hurriedly checked by some new person on a mechanized history form. Nor will it be assuaged by placing parturients in solitary confinement, because loneliness is Fear's greatest accomplice; nor by such last minute, if well intentioned efforts to help as, "Be brave, darling; other girls have lived through it before,"—this with a forced smile. Fear of childbirth will only be eradicated by a wholesale reconstruction of our entire antepartal program, by new emphasis on the patient as an individual, and by the introduction of cheer and some of the amenities of human relationships into every case. This is a huge assignment, one that will repay every effort put into it and one which—by the very nature of womanhood—can only be effected by the understanding heart, the delicate touch, and the intelligent appreciation of the maternity nurse.

The elimination of fear is but one phase of the mental hygiene of pregnancy; and the mental hygiene of pregnancy is but one of the many fields which make up the sum total of advanced maternity nursing. To develop these several fields a large number of nurses must be trained. At the present writing there is a deplorable lack of facilities for such training. It should be one of our goals to foster the nationwide creation of postgraduate courses in advanced maternity nursing,—not courses in which the postgraduate spends nine tenths of her time in routine nursing for the benefit of the hospital, but truly academic courses in which 100 percent of her working hours are devoted to receiving intensive instruction and training in the several skills required by her calling.

IN CONCLUSION, it would seem appropriate to comment briefly on the relationship which should exist between the obstetrician and the advanced maternity nurse. It would serve no useful purpose to gloss over the fact that many obstetricians have viewed with some concern the development of nurse-midwifery and have inquired skeptically: Just where are these nurse-midwives going and what are their ultimate objectives? Conversely, not a few nurse-midwives have spoken of lack of cooperation on the part of physicians here and there. If I am not mistaken, the underlying cause of this attitude on the part of obstetricians is the suspicion that nurse-midwives hope ultimately to take over the conduct of normal maternity

cases in this country, referring to obstetricians patients with complications, more or less according to the Scandinavian pattern. I am certain that the nurse-midwife group has no such intention. It is true that in many localities of this country a home delivery program by nurse-midwives under public health department auspices has a highly important role to play at the present time. We have such a program in Maryland and are most proud of it. But this policy should be regarded, in my opinion, as a temporary expedient only, our ultimate goal being the delivery of all women in hospitals by obstetrical specialists. That the latter objective is an entirely practicable one to strive for has recently been demonstrated by Dr. Edwin F. Daily. To me, the many facets of advanced maternity nursing other than strict midwifery—important as the latter may be in certain areas today—offer more fertile fields for cultivation in any long-range program than does the technical procedure of delivering babies. These fields of advanced maternity nursing are on just as high a plane as those of the obstetrician, and in many instances require more originality of thought, more constructive planning, and more finesse. Let these fields now be delineated; and may it be particularly stressed that there is no conflict or overlapping between the field of the obstetrician and that of the maternity nurse. Indeed, only if we work together as partners will the best interests of our two professions and of motherhood be served.

Presented at the Biennial Convention, Atlantic City, New Jersey, before the Nurse Midwifery Section, NOPHN, September 23, 1946.

Community Nursing

(Continued from page 640)

"WHERE DO WE START?" is the question many nurses may ask. The only answer is to start where one is with what one has. It is not necessary to organize a community nursing council at once. It is enough to find two or three interested persons and have faith that ideas well planted will grow. Even this first step may give some nurses pause for fear they may not be able to answer all the questions that the consumers may ask. That is so often the weakness of a professional person—to take herself too seriously.

The nurse does not have to know all the answers. She only needs to know some of the technical resources, local, state, and national, to which she may tell the people of her community to turn for help in solving their community nursing problems. Some of these technical resources will be found in the nursing and other professional groups. Other resources will be found in universities and in private and public agencies especially concerned with health services. Still others will be discovered close to home among the farmers, business men, housewives, teachers, and county agricultural and home demonstration agents who have had rich experiences in community organization for a wide variety of important programs.

And so, if nurses in every community will decide on the first step that must be taken toward building a comprehensive nursing service—and take it—the next step will come more easily, and the next and the next still more easily. Then the time will come sooner than expected when nurses, with an abiding faith in the future of their profession and an enduring trust in the cooperation of the people they serve will have won their long sought goal of equal opportunity of nursing and all other health care for all the people.

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Is Nurse-Midwifery the Solution?

By SISTER M. THEOPHANE SHOEMAKER, R.N.

DURING THE PAST thirty-five years a cry has been reverberating throughout our nation for adequate maternity care; for more and better prepared personnel; for distribution of this service to reach all mothers. Progress has been made but we will all agree that there is a long way to go before every mother receives the kind of care she deserves for herself and her baby. The job is stupendous. It will require wholehearted cooperation and personal sacrifice of all those who join in the struggle for its successful completion. When such care is provided, the cry will cease; not before.

In 1942 twenty-five states reported from 10 to 46 percent of all maternity patients without skilled obstetric care.[1] Racial groups within the states showed an even higher percentage, and a number of individual counties reported almost a total absence of such care. These figures have been improved somewhat during the war. The Emergency Maternity and Infant Care program and the increased income of many families raised the percentage of mothers receiving medical obstetric service. What will happen during these first years following the war? Will the number of women receiving adequate attention during the maternity cycle increase or decrease? The answer to this question, I believe, will depend to a large extent upon the nursing profession. Therein lies an irresistible challenge.

The challenge is not a new one. In 1912 when the so-called "midwife problem" was receiving so much publicity, a solution was offered by Clara D. Noyes,[2] who proposed that trained nurses be given additional preparation as midwives in order to give full maternity care to normal patients. Two years later, Fred Taussig, M.D.[3] at the annual meeting of the NOPHN, proposed a full program for the training of nurse-midwives. He recognized that the challenge was great and that nurses were not yet prepared to accept it. He predicted that full acceptance of the nurse-midwife would be a lengthy process. He was right. It did not happen over night. Not until 1925 did it begin to take concrete form when, in the mountains of Eastern Kentucky, Mary Breckinridge blazed the trail and within a few years demonstrated how nurse-midwives could reduce the maternal mortality rate, even under the most primitive conditions, to less than 2 per thousand live births.

In 1932 the Maternity Center Association in New York City, in face of vehement opposition, organized the Lobenstine Midwifery Clinic and School. We are all proud of their heroic venture. Lobenstine has graduated 125 nurse-midwives, well prepared to give the kind of maternity care we would like all mothers to receive. At the same time thousands of women in upper Manhattan Island and in the Bronx have terminated their pregnancies with sound health, better prepared for the job ahead of them.

Other similar programs have been organized—some for service, some for a combination of service and training of personnel. Of the seven schools opened specifically for training nurse-midwives, three are active today. There have been successes and failures and from these we have learned a great deal.

For 21 years nurse-midwives have been working in this country. They have battled with obstacles to maternal and infant health under a great variety of circumstances and have attained remarkable success. As a result, it seems eminently possible that well planned programs of maternity care, given by nurse-midwives in collaboration with properly quali-

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fied physicians, may prove a permanent solution to the "how" of providing adequate maternity care to all.

For our immediate purpose, let us consider the factors that up to now have been of major influence in enabling nurse-midwifery programs to be successful. They are (1) choice and preparation of the community which is to receive the service (2) good organization within the agency giving the service and (3) excellent obstetric care within the financial possibilities of the family and adaptation of care to its particular needs.

CHOOSING AND PREPARING A COMMUNITY

Determining where nurse-midwifery programs should be established is not easy since criteria for determining needs are not established. There is a variety of opinion regarding the place nurse-midwifery should have in the obstetric program and this disagreement hampers progress. In general, however, we may say that wherever a community exists without adequate facilities for obstetric care for all of its mothers, there is room here for a nurse-midwife on the obstetric scene. If obstetric care were available in all communities and if the services of the nurse-midwife were an integral part of all obstetric programs, the choice of community would be unnecessary, because the nurse-midwife automatically would be included in each community's program. Since this is not the case it is necessary to conduct a careful survey before choosing a community in which to establish such a program.

Instead of going into the details of procedure for a survey which are, of course, of great importance, I think it more helpful to tell you how we met this problem in Santa Fe, New Mexico, where we opened a school for nurse-midwives and a direct service program two years ago. The method we used proved very successful and has since been used with slight modifications in two neighboring communities with equal success.

The need for a nurse-midwifery program was well recognized by the health authorities in New Mexico long before 1943 when we agreed to go there. In 1942,[4] 43 percent of the Spanish-speaking mothers in the state as a whole were having their babies without skilled attendants; 38 percent were using so-called "granny" midwives. In Santa Fe County where there were 13 practicing physicians, 31 percent of the Spanish-speaking women were having these untrained midwives at the time of delivery with practically no antepartal or postpartal care. There was no question about the need. In this case, community preparation began through meetings sponsored by the State Health Department, the County Medical Society, and the Archbishop of Santa Fe. All were agreed upon the importance of a nurse-midwifery program and all pledged their cooperation to the new enterprise which, from the beginning, involved a school for nurse-midwives.

An efficient wedge was provided for us through a general clinic and from this we became an integral part of the community of Santa Fe. For three months we did no midwifery other than that involved in a prenatal clinic. We became acquainted with the families, learned to know the leading citizens among both the Spanish- and English-speaking groups. We visited every health and social agency and met their officers and staff members. We went on home visits with the public health nurse as a means of learning the importance of tiny alleys and the humble homes to which they lead. We talked with hundreds of mothers, both at the clinic and in their homes, and from them we learned that the people are for the most part very poor, uneducated, proud of their culture, and sensitive to protect it. They are willing to accept good care but unwilling to be served by professionals who may not be sympathetic. We found them to be a social people, full of hope that we could help them in a human way.

One of the greatest contributors to our early success and to the progress of our work, was Nancy Campbell, M.D., an obstetrician, who from the beginning has been the medical director of our program. She is convinced of the special contribution nurses trained in midwifery have to offer, and it was she who persuaded us to start doing home deliveries several months earlier than we had planned. Over and over again she told patients about our work and said to them: "Go to the Sisters, because they are trained as nurses and as midwives to give good care. If complications arise, the doctor who is especially equipped to care for abnormalities will be called. And if necessary hospitalization will be provided. The nurse-midwives can give better delivery care

because they can give more time throughout labor and delivery than I or any other physician can afford to give."

We became acquainted with the newspaper staffs and from the beginning of our program news items and feature articles have appeared regularly in the county papers. On several occasions the local radio station made announcements for us and we have found that if the program director is acquainted with the work and the personnel, he will give constructive advice and will cooperate in making its activities known to the public.

Establishing contacts with the community is a continuous process and requires constant study and planning. It continues even after the service is set up and in action, for communities are not static. New families are being formed; new babies conceived and born.

GOOD ORGANIZATION WITHIN THE AGENCY

The second *sine qua non* for success is good organization within the agency. We have found in Santa Fe that elaborate physical facilities are not necessary. Definite equipment is needed for any good maternity service and we have provided this. But, in addition, we have learned that an atmosphere of friendliness can be created by providing an attractive physical set-up and by maintaining a proper attitude toward the patients on the part of the personnel. Every member of the staff, professional or lay, must not only show but feel within herself a keen interest in the patient's well-being. It should be the kind of interest that will cause the nurse-midwife, the attendants, and even the physicians, to take the trouble to find the little ways in which they can help the patient. It should be the kind of interest a friend has for his friend.

Since the staff members at the Catholic Maternity Institute rotate for delivery calls, the patient is never assured that she will be attended by any specific nurse-midwife. There must be, therefore, such a spirit of unanimity and professional skill that the patients have equal confidence in all. In a nurse-midwifery program there is no place for even one person who does not have the confidence of all patients, and such a situation can be avoided very easily if a friendly, self-giving attitude is universal within the agency.

Physicians who work in collaboration with nurse-midwives must also possess special qualifications. Concerning these, our medical director, Dr. Campbell, has written:

> It is extremely important that physicians who work in cooperation with a nurse-midwifery program have training that is definitely superior to that of the general practitioner and to that of the nurse-midwife so that there will be a real advantage to be derived from consultation. It is also important that the physician recognize the value of the work done by nurse-midwives. The nurse-midwife lightens the load of the physician by relieving him from attending normal confinements. When he is called for consultation he knows before he arrives in the home what to expect and when he reaches the patient he has expert assistance. It is also essential that the physician . . . recognize the teaching value of a nurse-midwifery program.

The greatest recompense to nurse-midwives for all their efforts, fatigue, and irregular hours is the satisfaction they derive from their work. Nevertheless, a just salary in keeping with their individual and professional responsibilities, is an obligation on the part of the administrative body. They must always remember, however, that they belong to a profession and they cannot expect to receive financial recompense in proportion to what they do for the patients, for who can estimate the value of even one life saved?

GOOD OBSTETRIC CARE

Regardless of how well selected and prepared is the community, or how cooperative and efficiently organized the staff, the major objective of the service will not be attained unless excellent care is given. For this type of obstetric care the nurse-midwife must be thoroughly grounded in obstetrics, skilled in conducting related procedures, and imbued with an appreciation for the dignity of the human beings whom she attends. This knowledge of obstetrics which she must possess is essentially a knowledge of the normal conditions encountered in the maternity cycle and the normal physical and educational needs of the mother.

Once procedures for normal obstetric care are understood, their skillful execution will come with properly supervised practice. The mechanical execution does not require an unusual ability on the part of the nurse-midwife, but in order to adapt procedures to individual needs, discernment is necessary.

The nurse-midwife must have a well formulated philosophy of life which applies in her daily living. It provides a stabilizing factor

which influences her attitudes toward patient care and also supplies a motive of sufficient power to be stimulating. In a work so closely associated with the process of generation, it is important to recognize the sacred character of conception and birth, the purpose of life and the ultimate destiny to which life is the pathway. Parents are not creators; they are co-creators. They supply the material and the conditions for conception; God creates the spiritual part of the body, the soul, which gives life to the new being. The patient, whether mother or child, therefore, possesses both material and spiritual nature and both of these must be considered in giving care. A deep appreciation of the psychological factors in pregnancy should be developed. This requires earnest reflection and genuine sympathy.

Excellent obstetric care comprises all these things. In our present economic order there is a further consideration to make and this regards the cost of obstetric care. We have already said the quality of this care should be identical for all mothers regardless of their ability to pay. This does not mean that it should be given free to all. On the contrary, families should pay for such care in proportion to their economic status and according to the material value of the service rendered.

Another source of expense to the family having a baby is hospitalization during confinement. When families cannot reasonably save the money to pay for this it seems the logical thing to provide care in their homes. There are, indeed, distinct advantages in a home confinement which I will not enumerate.

SELECTION OF STUDENTS

So far, I have said nothing about schools of nurse-midwifery. As space is limited the one thing I would like to emphasize is the importance of selecting students. Nurse-midwifery is in the pioneer stage. For this reason nurses who plan to enter this field must have a pioneer spirit. They must be ready and willing to overcome obstacles which interfere with good maternity care. They must realize at the outset that they are entering one of the most difficult branches of nursing where personal interests must be secondary at all times to the interests and needs of the patients. The nurse-midwifery student must be mature. She must be resourceful in order to live happily in areas where she is obliged to create a good part of her own recreation. She must be flexible enough to adjust her personal life to meet the demands of the inevitable irregularities of a maternity service.

She should also have an inclination for study and research and a proper educational background. One reason this is necessary is that she must be prepared to defend her decisions with objective facts, not only when this is required by the organization itself, but also by others who are interested. Her ideal of service should be the care of mother and infant. This ideal is in keeping with the real need for good maternity care that exists throughout our nation.

Good maternity care has been of great concern to the medical and nursing professions in this country since the year 1912. In the ensuing interval, various proposals have been made to eliminate poor care and supply the best that science has made available. Although in certain areas it has been possible to reach all mothers through the establishment of various types of services, who can say that all have benefited? We know that in many parts of the United States mothers are still receiving the type of care against which such opposition was raised in 1912. Physicians and nurses must not rest until all mothers in all communities are receiving the best maternity care.

We must remember that in all new fields of endeavor success is attained only after inevitable mistakes have led to better methods. Nurse-midwifery is no exception. I am convinced from a study of the development of nurse-midwifery in the United States that the failures in the past have come about not because nurse-midwifery has not filled a real need, but rather, first, because there have been no official standards for selecting and preparing nurse-midwives, and secondly, because some of the programs have been poorly planned—without well formulated policies, and this has led to conflicting professional relationships.

Let us see in the response which nurse-midwives have already made to the reverberating call for adequate maternity care, a promise of good things to come. When professional nurses, inspired with the possibilities of assisting other women in the critical time of childbirth, generously give themselves to this noble work, then a large proportion of the na-

tion's mothers which have hitherto been neglected, will at last receive the excellent obstetric care that each deserves.

Presented at the NOPHN Nurse Midwifery Section meeting, Biennial Convention, Atlantic City, New Jersey, September 24, 1946.

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THIS IS CHRISTMAS

May all true happiness come
Early this holiday time and
Remain with you. May all
Real Charity be among us this
Yuletide.

Children the world over, all
Hold this season dear. Their cries
Ring out. Their cries ring out. But
Is this the sound of merriment?
Small voices can cry with hunger
Tear dimmed eyes grow big with fear—
Must such things be, oh Lord!
And shall we do naught to
Solace them?

For each one's need is small
Requiring little from our riches
Oh, come let's give together this
Merry Christmas.

Now among us come glad days—
Only Charity is real joy.
Peace spread your mantle o'er the earth
Heaven smile upon us all—
Now.

—H.C.

Rehabilitation for the Hard of Hearing

By MARY WOOD WHITEHURST

WITH adequate rehabilitation there is no valid reason why the vast majority of the hard of hearing should not be psychologically, socially, and economically adjusted to the society in which they live.

Successful rehabilitation has three stages. First, the person must *face* the fact that he is hard of hearing and stop dodging the issue; second, he must intelligently *accept* the fact that he is hard of hearing; and third, he must *do* something about it.

What can he do about it? The answer is a great deal. The army and navy centers for hard-of-hearing service men have given positive evidence of what can be accomplished. Theirs was and is a progressive and realistic program which provided rehabilitation for every deafened person regardless of his degree of loss. Nobody was allowed to lie down and "take it." Each was taught how to meet his own individual problems so that when he left the center he went with a greater feeling of self-assurance and with a minimum feeling of handicap.

How was it done? Briefly the procedure can be outlined as follows:

1. Each soldier was given an ear examination by a staff otologist and treatment was administered, if necessary.

2. He was scientifically fitted with a hearing aid if his degree of loss warranted it.

3. He was taught how to use this hearing aid and given 30 hours of auditory training which enabled him to get the maximum efficiency from his hearing.

4. He was given 30 hours of lip reading which taught him to follow conversation by watching the faces of people, particularly their lips. He learned to hear with his eyes, as well as with his ears.

5. He was given speech correction and taught how to regulate and modulate his voice through his new hearing aid.

6. He was given vocational aptitude tests to determine what particular skills he had and what type of job would permit him the best utilization of these skills.

Every phase of the program fitted together neatly like the parts of a jig-saw puzzle, so that at the end of an eight-weeks' course each man went out with a confidence in his ability to resume his place in a society from which he had withdrawn. He felt equipped to compete with his normally hearing friends with less strain and with more assurance than ever before.

What was done for the service man can be done, and is being done in a few places, for the civilian population. These are some of the important features of the program which are now being offered to the hard-of-hearing public.

HEARING AIDS

The vacuum tube hearing aid with its recent developments is undoubtedly the greatest contributing factor to successful hearing rehabilitation. Learning to hear through the older, noisy carbon types was often so tedious and unsatisfactory that the user lost interest in trying to hear. The improved quality and efficiency of the vacuum tube instrument has changed the attitude of the hard-of-hearing public towards wearing an aid.

And again, the advent of the "monopak" (the all-in-one instrument) has done much to popularize the hearing aid. Very small batteries are encased in the instrument. This eliminates the extra heavy battery pack which has always been a source of annoyance to both men and women. At this point, however, a word of warning should be issued to the prospective buyer. If he has a severe loss, he will find the instrument with the separate battery pack stronger and more effective. Likewise, if he expects to operate the instrument

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at a minimum cost, this older model is the one to consider. Small, tom-thumb batteries in the monopak do not give as many hours of service as the larger ones.

Because there are effective and ineffective aids on the market, and because it is so important that the individual get the hearing aid best suited to his needs, he should go to a hearing aid clinic for consultation and advice. At such a clinic he will be scientifically tested on different types of instruments and be advised in his selection of one by a competent, impartial consultant. This is the only way to be properly fitted. There is no one hearing aid that satisfies every type of hearing loss.

AUDITORY TRAINING

After the person has been fitted with a hearing aid he must be taught how to use it skillfully, so that he may get the maximum efficiency from his hearing. Such training of the residual hearing is called auditory—sometimes auricular or acoustic.

The question is often asked, "Why is it necessary to train a deafened person to use a hearing aid? Does not the hearing aid automatically correct the hearing impairment just as glasses automatically correct a vision impairment?" The answer is *no*. A hearing aid only amplifies the sound. In some uncomplicated cases this amplification is sufficient to produce the desired results, namely, to understand speech with a minimum of effort. Such a person is lucky because the majority of cases do not find adjustment so easy, particularly losses of long standing. Their hearing has suffered from disuse. Consider a very homely comparison. If a broken arm had been in a cast for weeks would it be logical to expect normal use of that arm as soon as the cast was removed? Certainly not. You can readily see the analogy to impaired hearing. Before the hearing aid is put on and before the hearing is retrained, the sounds that reach the brain and the interpretation of these sounds are so distorted and garbled that they are often meaningless. Certain vowels are incorrectly heard and many consonants are not heard at all. Such a person must learn to re-hear these sounds accurately and this can be done only through the most painstaking training.

Auditory training not only brings about better understanding of speech but also quickens the mental processes which so often have begun to slow up. Sometimes the slowing-up is so gradual that the individual does not realize it. The quickness and alertness with which he used to respond to sound stimuli are now missing. He may continue to keep his mind informed by extensive reading but that keen auditory alertness can never be attained and maintained without continuous practice. Therefore, to preserve and improve hearing one must learn how to use it with maximum efficiency. And the only way to preserve it is to use it.

There are certain problems connected with the wearing of an aid recognized by all users. Learning to understand speech is one thing but understanding it through a background of sound and often noise is another. With certain types of deafness this, at first, seems an insurmountable difficulty. Merely learning to endure this "background" is a tedious process but it can be assisted in great measure by persistent, intelligent training. The pupil can be trained to ignore the distracting noises that come through his aid and concentrate on the thing at hand. Auditory training teaches him how to listen and what to listen for—and conversely, what *not* to listen for.

It is important that a new hearing aid user be re-introduced to a sound world gradually. Otherwise the sudden impact of sound is devastating to his whole nervous system. Little by little he must build up a tolerance and endurance for sound until eventually he does not want to be without it. It has been my experience that few, if any, pupils carefully trained and with real need of a hearing aid, will part with that aid during many of their waking hours. There are exceptions, of course, such as the person working in a noisy place or the extreme nerve case. But under ordinary circumstances, in relatively quiet surroundings, the well trained user will keep that instrument on whether he is talking with people or not. He has been taught to understand that a sound background is a normal one for hearing people. Why not for him? He now realizes that he cannot stay in silence part of the time and expect to adjust to sound instantaneously. And that the more he disregards sounds the more difficult this adjustment becomes. He has acquired tolerance for the sound background, in some cases with great difficulty, and knows this can be retained only by continually sur-

(Continued on page 658)

Labor's Part in Community Affairs

By WILBUR F. MAXWELL

THERE WAS A TIME when community activities and services, which were supported by voluntary contributions, secured their money from a small group of "well-to-do" people. Among these, there have been many fine examples of generous citizens who have considered their wealth as a stewardship and who have accepted membership on boards of directors as representatives of the community in a very true sense. More often, however, contributions have been made on a basis of individual ownership of wealth, and board membership has been accepted in the same spirit. The contributor has been apt to say "I gave my money to support this work and my ideas should be carried out in the program of the organization."

With the advent of federated community-wide campaigns for the financing of social service, there has been a great change in the basis of support of voluntary social service which has not been paralleled with a corresponding change in the membership of boards of directors. The base of giving has been tremendously broadened to include as high as one in four of the population. In place of "charity" in the narrow conception of gifts handed down from the more fortunate to the "deserving" poor, we are today saying, "Everybody benefits—everybody gives."

It would be unfair to say that no efforts have been made to broaden the representation on boards of directors, because with the lifting of the money-raising problem from individual social agencies, under federated financing, it became feasible to elect as board members persons who had valuable experience and ability but who could neither give large sums themselves nor influence large gifts on the part of others. In the main, these additions to the membership of boards have been professional people and they have made great contributions to the work of the organizations with which they have been affiliated.

There has been no plan of representing the people to be served, the clients of a particular agency, on the board of directors; in fact, the idea has been contrary to prevailing opinion in our organizations. There is in this a trace of that old feeling that people who are being served by non-profit or charitable organizations should be grateful for whatever they get. Why should they have a voice in setting up the program to serve them, we have been inclined to say. This idea was given a real jolt in the depths of the depression when thousands of families to whom the idea of accepting relief was repugnant, found themselves applying for aid to public and private agencies. That bitter experience, which we never want to see repeated, brought realization that our organizations cannot be set up to serve just a segment of the population. Every citizen is concerned with their successful operation. In other words, we now recognize them as truly community enterprises.

Now, under this modern conception of community organization, representative leaders, working through appropriate machinery, endeavor to discover community needs and to set up services to meet them. Not only must there be an over-all plan and program for the community, but each social agency must be a replica of the general plan, in its own particular field, with proper coordination into the whole, if service is to be effective. This is a far cry from the problems which were faced when the constant question before directing boards was that of raising of funds to meet pressing obligations. The directing board today should be widely representative in its membership.

In the organization of a representative

Director of Labor-Employee Participation of Community Chests and Councils, Inc., Mr. Maxwell is well qualified to approach the subject of agency-labor relationships.

board of directors outstanding men and women can be recruited to contribute the viewpoint of every important group, and in the normal process of replacement of members of existing boards similar broad representation can be achieved.

My particular assignment is to speak for representation of organized labor on boards of directors. This is an easy task because of the war experience which brought a development of great significance in this field.

Due to a fortunate chain of circumstances at the beginning of World War II, the two great groups of organized labor, throughout the war years, have taken an active part along with other citizens in the planning, operation, and support of voluntary agencies in the field of health and welfare, in addition to their activities in behalf of public agencies and their support of war agencies. This has been a new experience and, generally speaking, it has been a very satisfying one and one not likely to be quickly forgotten.

During the war these two national groups, through their war relief committees and through volunteer representatives of organized labor in hundreds of communities, became interested in local voluntary agencies in the field of health and welfare which were financed through the joint campaigns in which they took part. Traditionally, unions have favored welfare projects supported by union members for their own group or public agencies supported by taxation. There has been a good deal of question about agencies supported by private contributions.

First-hand contact by union members with these voluntary agencies has brought a new conception of their value. Union members have found, in the main, that these agencies know their jobs and that they dovetail with public agencies so as more adequately to serve the community, and do it without duplication of effort. The principles under which the agencies operate are quite acceptable to the unions. They are considered, on the whole, to be fair and proper. The experience of relationship between the unions and these agencies during the hectic post-war adjustment period has been quite satisfactory.

There is no readily available check on the number of representatives of organized labor who are now included on social agency boards and committees, or the increase over previous periods, but we know the number has grown from something like a couple of hundred at the beginning of the war to at least five thousand at present. This increase seems to indicate rapid development of the idea and, we can assume, satisfactory relationships.

There is an essential difference between the usual methods of recruiting board members and the problem of securing representatives of organized labor. Most board members are approached as individuals rather than through organizations or groups with which they may be affiliated, but in the case of organized labor, where the group is of prime importance, the approach should be through the central body of the particular labor group. A panel of candidates for the particular position can be requested and a choice can then be made from the panel with due notice as to the appointment as it is finally worked out. If this is done you can be sure there will be recognition on the part of labor groups of the appointment and the member concerned may be asked to report to the central labor body at intervals.

There are special difficulties in the way of securing the full cooperation and participation of representatives of labor who become members of boards. In the first place, there is the familiar difficulty of concentrating such representation on two or three well known labor leaders who are already so very busy they cannot be of value in any new position which they may accept or which has been forced upon them. It is well to discuss this with the central labor body and with any candidate so that some understanding may be reached in advance. If we are to make the experience of board membership valuable to the agency and to the member who comes from labor, we must get beyond the top labor leaders who have so little time to give, and reach a second line of men and women in labor who do have time and an interest in our work.

Even the time and place of board meetings is important in relation to representatives from labor. I do remember the extreme case of the settlement house where they had no representative of labor on the directing board, and when surprise was expressed at the oversight, assurance was given that it was no oversight. The board of directors of that settlement, I was informed, often met at the homes of its wealthy members and representatives of labor would be out of place in such meetings. But,

forgetting such an unfortunate extreme, there is the question of the loss of working time and the expense of meals which are problems for many representatives of labor. Fortunately, a good many employers have recognized the advantage of developing leaders in the ranks of labor who are acquainted with community problems and resources, and provision has been made for payment of time rates and even meal expense covering attendance at meetings. Sometimes unions have made such arrangements.

Just a name on a list of board members with no indication of interest or activity, does nobody any good. If you have representatives of organized labor on your board who never attend meetings and are inactive, do something about it. See the members and, if they cannot attend and be active, request their resignations. If this does not work, appeal to the respective central labor bodies. These are situations where a bylaw which creates a vacancy when a member is absent from three or four meetings without satisfactory excuse, would prove a godsend. Another safeguard is a plan of compulsory rotation of membership of the board through a bylaw which stipulates that no member of the board, after serving a full three-year term, is eligible for reelection until after the lapse of a year.

There is an obligation to use and not abuse board members. No agency can have an active and interested board unless the board is given a real job. There are too many meetings anyway. It is a waste of time for busy people to be called together just to hear a report which might just as well have been sent through the mail.

Surely, no argument is needed as to the value of the point of view of working people in formulating policies and operating service where they are the chief beneficiaries. Here is representation not only of a great body of potential and actual givers, but representation of the clients of the agency, the people to be served.

In the matter of voluntary support of social and health agencies, we cannot expect generous contributions from working people without some plan of participation which will develop and maintain their interest. Educational plans and "Come and see" trips help greatly, but inclusion of representatives of organized labor on boards and committees is definite and concrete. The potentialities of intellectual, moral, and financial support from this group are very great. A great deal was achieved in this direction during the war, but only enough to indicate greater possibilities for the future.

Whatever our differences are in other fields, we need and must have unity in the field of health and welfare if we are to discover the problems to be solved and if we are to secure the resources needed in their solution. The inclusion of representation of organized labor on directing boards and committees is a big step toward such unity.

Presented at the symposium, "Board of the Future," held by the Board and Committee Members Section, NOPHN, at the Biennial Convention, Atlantic City, New Jersey, September 25, 1946.

NOPHN Membership Supper Rally

IN SPITE OF LABOR difficulties, food shortages, trucking strikes, and taking a chance on paying for a definite number of suppers weeks before the Biennial, we were delighted when 650 members of NOPHN with an overflow of onlookers in the balcony, joined in the membership supper rally in honor of Mary S. Gardner on September 25. We're sorry to say about two hundred more were unable to buy tickets because of the definite limit made by the Hotel Chelsea and it was with regret that all could not be included. Hawaii and Manila had representation and even a guest from Oslo, Norway, and members from 42 states were on the advance reservation list.

Alma Haupt, who was to have been chairman of the dinner, became ill and Sophie Nelson did a spirited job as substitute chairman on twenty-four hours' notice.

Student nurses from the Atlantic City Hospital led the guests to the two speakers' tables on the stage whereupon a hand-picked quartette led off with singing "How do you do." After a special introduction of all those who had taken part in developing nurse and lay membership in the states, Helene Buker, National Nurse Membership Chairman, reported there are now 10,613 members; 9,257 nurse members and 1,356 general members. Of these 215 are sustaining and 123 life members. Total membership shows an increase over last year of about 500, the result of untiring efforts of the membership representatives.

Caroline di Donato presented greetings from the Hostess State and an orchid to Miss Gardner to mark this special occasion.

The theme "How to get a Member" was developed in a series of original monologues by Elizabeth Reed, director of the VNA of Jacksonville, Florida, which brought down the house. The director's militant approach, the Southern gal's technic, the harassed board member's request, and the statistical attitude, were pictured as ways to get a member.

Miss Haupt's tribute to Miss Gardner was read by Miss Nelson:

It is our privilege tonight to pay honor where honor is due. The honor is paid to the public health nursing movement through its star—Mary Sewell Gardner.

In *Katharine Kent,* Miss Gardner's latest book, one of the main characters is Dr. Waldron, the grand old man of public health who lead Katharine Kent into public health nursing. Dr. Waldron says, "The star is always there, dear Miss Kitty, and always the same. It is only the wagon which sometimes misbehaves."

To Miss Gardner, the star is public health nursing; to her followers in public health nursing, she, herself, is the star. For it is through her luminous light that there is reflected to her followers in the wagon of public health nursing, the world-wide influence, national significance, and state and local implications of public health nursing service for the health and welfare of people.

Although Miss Gardner claims that *Katharine Kent* is "not a biography nor an autobiography," certain old-timers like myself can be "suspectitious" about some of the characters and incidents in this book.

But rather than embarrass Miss Gardner by a dispute over truth or fiction, we present a bit of free verse anent "Katharine Kent's" idea, from her own words, of the public health nurse's qualities—be she director, supervisor, or the valued member of a staff. We suspect that they reveal Mary S. Gardner herself.

She's frightened at first
  Because of the lives,
She aids and has to supervise,
  Problems of illness, preventing disease,
Desertion, divorce, and doctors to please.

Meetings with Boards and Community Chests
  Reports and budgets and such other pests
Relations with families, courts and case workers
  Fits of rage to control when she tangles with shirkers,
To meet these diversities
  She must possess
Ingenuity, spunk, and expressiveness.

As supervisor she struggles to face
  That on other shoulders she must place
Responsibility and share the woe
  When the best laid plans will not go.

A cock-sure spirit with keenness for living
  Plenty of courage, perseverance in giving,
Judgment exceptional—vision above it
  A love of adventure and quantities of it.

MEMBERSHIP RALLY

Skill in planning for purposes various
"A way with her" in situations precarious
Thinking always deep and wide
Of science and the human side.

From "Katharine Kent," we now turn to the real Miss Gardner:

It's her radiant self that makes us adore her
And place our respect and affection before her,
Her many achievements, her star of endeavor,
We pledge now to follow forever and ever.

So to Mary S. Gardner,
The star of our cause,
We greet you, and thank you
With this,—our applause.

Miss Gardner's response was meaningful for all the members of NOPHN:

This is a membership rally and I must get to the rally part of the meeting for I know how dangerous a white-haired female, without a written speech, can be on a platform.

Rallies and membership drives do, I know, *get* members, but does any kind of a pep talk ever *hold* membership? If not, what does? In other words what makes an organization like the NOPHN a living force in the world? What does it live by?

I believe that the NOPHN, like other organizations of its kind, lives by the quality of its inner life—by the quality of its aspirations and its thinking as well as by the value and success of its outward activities.

May I give you briefly under perhaps a half dozen headings the fundamental elements by which I believe such an organization lives?

The worthiness and vitality of its purpose.

The wisdom, strength, and vision of its board and committee members.

The competency and breadth of outlook of its staff.

Its ability to hold the interest of its more mature members and its equal ability to attract the interest of the young.

Its willingness, founded on sound judgment, to enter new fields.

Its generosity and understanding in furthering the ends of allied organizations.

I feel sure that the purpose of the NOPHN is unassailable for with all its many ramifications, as a whole it stands for the simple Christian virtue, or rather duty, of helpfulness to mankind.

With so much that is good in the past, I think that our foundations are sound but it is the future that must concern us now. Have we enough of wisdom, enough of vision, enough of courage, enough of strength to carry us forward into the new era that is before us? According to our various points of view, we have been thrilled, surprised, appalled or delighted by the recommendations of the Structure Study which we heard yesterday. It is too new to all of us for comment at this moment, but let us strengthen ourselves with a larger membership than we have ever had before so that with all our banners flying and no fear in our hearts, we may go forward into a greater usefulness than our dear NOPHN has ever before been capable of.

As the ideals and trail blazing of the past must be carried on by the future generation it was suitable for Mary T. Clarke, a student nurse at Atlantic City Hospital to say, as she presented Miss Gardner with an engagement book marked for her "From NOPHN Biennial 1946," "Miss Gardner, I represent tonight the generation of young nurses, students now, who will go forward in the future inspired by the leadership of the past. As the outstanding person who has worked for many years in the interest of Public Health Nursing, may I offer to you a reminder of this dinner in your honor. As you have filled many years of engagements in the interests of your profession, we felt sure you would continue to fill the next 365 days just as full. We hope this will help you keep track of a busy and inspiring life."

It was evident that all wished our membership of 10,613 could have joined in the song, "Ten thousand, we're ten thousand, all members strong and true," as the 1946 Biennial membership rally ended.

WANT TO WORK IN HAWAII?

An opportunity for public health nurses to work for a year in the Hawaii Health Department is now offered under the new exchange personnel program inaugurated by the Board of Health in the Territory.

Provisions in the act state that each person must possess qualifications equal to the qualifications of the person exchanged for him from Hawaii and must hold in the state health department a position which is equivalent to the position held by the person exchanged for him in Hawaii. Salaries for both exchanging parties will be paid by the home employer.

For further information write to Dr. Richard K. C. Lee, assistant health executive of the Board of Health, Territory of Hawaii.

The Board in a Combination Agency

By MRS. J. GEORGE MULDER

I HAVE BEEN asked to explain how the board of a combination agency—including health department and visiting nurse service—functions. Montclair has what is considered a fairly satisfactory combination agency but, as it came about as the result of gradual development, I should like to tell a little of its history.

Previous to 1928, there was no coordinated health service. Child welfare, tuberculosis, and venereal disease nursing were under the supervision of the Health Department. The Red Cross had seven nurses and a supervisor who were responsible for bedside nursing, maternity and orthopedic nursing. Public school nursing was administered by the Board of Education. Then the Council of Social Agencies requested a survey by the National Organization for Public Health Nursing which resulted in the recommendation that a coordinating nurse be employed to effect a reorganization. This recommendation was followed and the consolidation of the two existing nursing services was accomplished in 1930. There was to be a six-months' trial which the Community Chest agreed to finance. At the end of this period, by agreement between the town and the Community Chest, it was arranged that the Chest pay two thirds of the cost of the public health nursing service and the Health Department the remainder. The town was divided into districts and each nurse was made responsible for all the public health nursing activities in her district, except public school nursing. The coordinating nurse was the director.

It was not until 1938 that the Bureau of Public Health Nursing was incorporated as a separate private agency and its Board of Trustees appointed to function primarily in an advisory capacity in relation to the budget and nursing policies. This private agency within the shelter of the Health Department was now the financial responsibility of the Community Chest, with additional funds received from patients' fees and insurance contracts. The town continued to be divided into districts and the nursing service generalized regardless of the source of its funds. This meant that, in practice, the Board of the Bureau became advisors to the nursing service as a whole, although it was not officially so designated.

At this point it may be mentioned that under our commission form of government the Mayor is the commissioner in charge of health and welfare activities. It should also be made clear that our health officer is a certified public health officer but not a physician.

By 1944 administration was becoming increasingly complicated, although the efficiency of the service was not affected. At the request of the Board of the Bureau of Public Health Nursing and of the Budget Committee of the Community Chest, the Council of Social Agencies invited the National Organization for Public Health Nursing to make another study of our public health nursing service and to submit definite recommendations for the simplification of the administration. It was a very thorough study and recommended that the private agency be more completely absorbed by the town; also that school nursing services under the Board of Education be combined with the existing nursing service. The last suggestion could not be carried out because the Board of Education was not yet ready to give up its specialized school nursing service.

Certain other recommendations were adopted immediately—one, in fact, even before the report of the survey was received

President of the Public Health Nursing Service of Montclair, New Jersey, Mrs. Mulder explains how the board of a combination agency has helped to smooth out certain complicated administrative problems.

It so happened that just at that time, the town voted the adoption of the state pension and retirement plan for all municipal employees. Therefore, all nursing personnel had been transferred to the town payroll to be eligible for these benefits. The bylaws were amended to provide for a rotating system of board membership and an enlarged and rotating professional advisory committee. The Board and Professional Advisory Committee were designated by the mayor as official advisors to the total nursing service.

The Professional Advisory Committee advises the Board of Trustees and the director on medical and professional problems. It consists of the health officer, the tuberculosis consultant of the Health Department, three physicians appointed by the President of the Associated Physicians of Montclair and Vicinity, and three by the president of the Bureau. These include one Negro physician and one dentist.

The other recommendations were studied separately by two special committees, one appointed by our Board of Trustees, and one by the Council of Social Agencies, each submitting a report. As a result, a contract was signed by the town, the Community Chest, and the Bureau of Public Health Nursing, providing for the Chest to pay on a cost-of-visit basis for all non-communicable disease nursing and for antepartal and postpartal maternity care, with any fees or partial fees from such visits to be deducted. The Chest also pays 25 percent of the cost of student and volunteer supervision, up to $1000. The town agreed to pay for health education services centered around the needs of the infant and preschool child, communicable disease control including syphilis, gonorrhea, tuberculosis, and adult health services. These include three child health conferences per week, two syphilis clinics per week, a chest clinic twice a month, and parochial school nursing. In 1947 the town will take over the antepartal care. Other items of expense in administration and maintenance are divided between the Bureau and the town, the latter carrying the large items of salaries, janitor service, office space, and the like.

PREPARING THE budget is one of the most important functions of the Board. In June our Finance Committee together with the president of the Board and the director of nursing service prepares an estimated budget for the total nursing service for the following year. This budget is first approved by the Board and then submitted to the Budget Committee of the Community Chest. In November it is reviewed once more by our Board. If there are major changes it is presented to the Chest. Finally at the end of the calendar year it is submitted with the health department budget to the town commissioners.

At the end of the calendar year the three agencies concerned settle their accounts for the past year. The Bureau submits to the Chest a statement of the actual cost of the visits made. If the total amount is more than the Community Chest paid the Bureau, the Chest makes up the deficiency.

The Bureau pays a monthly sum to the town, as called for in the budget. At the end of the year, it pays over to the town treasury any excess in the way of fees collected. A small working balance, however, is left with the Bureau treasury.

The responsibility of the Board of the private agency in its official capacity is largely advisory but it does have certain executive functions. It determines personnel policies relating to the minimum qualifications for appointment of staff nurses, which are in accord with nationally recommended policies. It also decides standards for employment, salary ranges, vacation time, and hours of work. The Board definitely supports certain legislation. Three times during the last year it has endorsed bills in Congress—the extension of the Cadet Nurse Corps, the social protection appropriation, and the school lunch program. It has given strong support to community projects such as the establishment of a dental health clinic. It has membership on the Council of Social Agencies. Its members are selected by a nominating committee, just as they would be in any private agency, but these have to be approved by the mayor acting as commissioner of health. Problems concerning janitorial service and car maintenance are settled in conference with town officials. The annual reports of our director of nursing and president are published in the annual health department report.

THE BOARD has complete freedom in conducting its public relations program and be-

lieves this program an important function in the interpretation of the nursing service to the public and also to the physicians. We have prepared leaflets for general distribution and sent a list of available services to the doctors. Last year members of the Board and staff gave five-minute talks before many civic groups. This has resulted in a much wider use of the service throughout the town.

As the Board sees it, the advantages of a combination agency far outweigh its disadvantages. The main disadvantage is the need to wait for town approval for so many things, from large items like addition to the staff down to small items like adequate cleaning arrangements for headquarters. On the credit side is the ability of the agency to give efficient service to an entire family through a fewer number of workers. This does not necessarily mean a lower nursing budget. In fact, its nursing staff may be better qualified and higher paid. But it does mean that the town is getting greater dollar value. The Board would not agree to too great an absorption of the private agency by the town. The strength of a private agency lies in its ability to inaugurate innovations which in their experimental stages could not fairly be charged to tax funds. There is a definite provision in the contract that any new service considered desirable by the Board of Trustees of the Bureau and accepted by the Community Chest as a service for which it should be responsible, shall be paid for by the Chest on a cost basis. It is the hope of both agencies and of the town that this ability to try new things will keep Montclair in line with the best that modern public health nursing has to offer.

Presented at the NOPHN Board and Committee Members Section meeting, "The Board of the Future," Biennial Convention, Atlantic City, New Jersey, September 25, 1946.

Hard of Hearing Rehabilitation

(Continued from page 650)

rounding himself with sound. He has been taught that the use of a hearing aid does not "tear down" his hearing. On the contrary, it gives him the best possible concepts of speech sounds. To preserve this concept he must wear his aid and use his hearing generously rather than sparingly.

LIP READING

A properly fitted hearing aid and auditory training are the first steps in rehabilitating the hard-of-hearing—but there is yet another important phase of this rehabilitation, namely lip reading. A hearing aid, no matter how efficient, can never recreate the perfect effect of normal hearing. There will always be occasions when certain speech frequencies are missing or drowned out by strong background noises. To offset these deficiencies which will arise from time to time every hard-of-hearing person, regardless of his degree of hearing loss, should study lip reading. By watching the lips of the speaker and by following the movements of speech he will be able to fill in the gaps and more accurately interpret the conversation. He learns to hear with his eyes as well as with his ears. One faculty supplements the other so skillfully that the person does not know whether he "saw" it or whether he "heard" it. It makes no difference. The important thing is that he understood it.

Thus, with the right hearing aid, and skilled guidance in its use, and the important additional help afforded by a knowledge of lip reading, the hard-of-hearing individual should live with a more confident self-sufficiency in this world of sound.

NOPHN Biennial Business Meetings

TWO MEETINGS of the NOPHN Board and two business meetings of the membership were held during the Biennial Nursing Convention at Atlantic City in September 1946.

NEXT STEPS IN THE STUDY OF STRUCTURE

Of first importance at these meetings was the action taken on next steps in the Study of Structure of the National Nursing Organizations. This matter was discussed at the first meeting of the Board on September 22, when certain recommendations were voted which were subsequently acted upon by the membership during the business meetings on Monday, September 23 and Friday, September 27, as follows:

1. Six members were elected as NOPHN representatives of an enlarged Joint Committee on Structure of National Nursing Organizations. These were: Ellen L. Buell, Mrs. F. S. Dellenbaugh, Jr., Katharine Faville, Alma C. Haupt, Hortense Hilbert, and Dr. Ira V. Hiscock. In addition, the president and general director are members, ex officio, of this committee.

2. The following functions for the joint committee were authorized:

a. To develop means of explaining to the respective membership bodies the various structure recommendations and obtain their opinions thereon.

b. To study and report recommendations regarding any revisions in the "Structure Report" to all the participating organizations.

c. To devise procedures for electing delegates and convening a joint reorganization convention or constitutional convention.

d. To prepare for submittal to the constitutional convention for consideration and adoption with or without modifications (1) drafts of constitutions and bylaws and (2) recommended procedures for giving effect to the action of the constitutional convention.

e. To arrange for ratification of the final actions of the constitutional convention by each organization.

f. To participate in the joint raising of necessary funds.

g. To take such other measures as may be found necessary to give effect to the desires of the governing bodies.

3. The NOPHN Board was authorized to allocate to the Committee on Structure ten cents for each member, this without any additional assessment of the members.

4. It was recommended that the Committee on Structure adopt a time schedule and work toward the goal of completing its work according to the schedule.

THE NATIONAL UNIFORM

Presentation of a national public health nursing uniform created much interest among members. The report of the Uniform Committee of the Board and Committee Members Section was read by Mrs. Mildred L. Hatton, vice-chairman, at the first business meeting on Monday. Mrs. Barbara Pless and Edna Stropagel of the NOPHN business staff acted as models, displaying the seersucker one-piece dress, seersucker suit, navy blue cotton dress, apron, navy blue wool suit, blue wool overcoat and blue felt hat. At the final business meeting on Friday, the national uniform was adopted for all public health nurses. It was further voted to turn back to the Uniform Committee the question of an insignia to be worn on the uniform with the request that NOPHN members make further suggestions.

Discussion revealed the countrywide interest among nurses in having a national uniform as a means of identification of the nurse to the public and the recognition that in encouraging nurses to wear a uniform NOPHN has no authority or wish to enforce its recommendation. It was the consensus that public health nurses receive adequate salaries and purchase their own uniforms.

PLANS FOR A SINGLE ACCREDITING BODY

Bernice Anderson, chairman of the Committee of the National Nursing Council to Plan for a Single Accrediting Body in Nursing, submitted the report of her committee to the Board on September 22. She stated

At Atlantic City NOPHN leaders talk over p'ans for the coming biennial period. Seated (left to right): Marion W. Sheahan, retiring president; Ruth W. Hubbard, newly ele cted president; Mrs. David K. Ford, 2nd V. P. Standing: Mrs. Gammell Cross, Mrs. Lloyd D. Brace, board members; A. Mary Ross, chairman, School Nursing Section; Ruth A. Heintzelman, Donna Pearce, Mrs. Langdon T. Thaxter, board members; Ruth Houlton, general director.

that the report marks the completion of the first aspect of the preparation of the total plan. Going back to the history of the committee, Miss Anderson explained that it came into being through the National Nursing Council. It was one of the segments of the "Comprehensive Program for Nation-Wide Action in the Field of Nursing" that were singled out for immediate action. There followed discussion concerning ways in which this plan differs from the accrediting plan in the "Report on the Structure of Organized Nursing." It was stated that the Committee to Plan for a Single Accrediting Body in Nursing will study the two plans for accrediting and make recommendations to the Joint Committee on Structure of National Nursing Organizations.

OTHER BUSINESS

Reports from the School, Industrial, Nurse, Midwifery, and Board and Committee Members Sections were made at the final business meeting. These reports will be found on pages 661 to 666.

The treasurer's report presented at the opening business meeting is printed in the Biennial Report. (See *PHN: News Bulletin*, September 1946.)

Officers and Board members elected for the 1946-48 biennium, as announced at the final business meeting, are listed on page A2 of this issue of the Magazine. The names starred were elected by the new board as members of the Executive Committee.

Resolutions adopted at the final business meeting were published on page 575, of the November 1946 PUBLIC HEALTH NURSING.

Revisions of the Bylaws as recommended by the Committee on Revisions and sent to all members were adopted. The main change was in relation to agency dues. Minimum dues for an agency if the nursing staff is 5 but less than 10 are now $25; if the nursing staff is more than 10, dues are $50. Associate agency dues were raised from $5 to $10. Another revision provides for general as well as nurse members on the Nominating Committee. Printed copies of the Bylaws will soon be available.

Ruth Houlton, R.N., Secretary
NOPHN Board of Directors

NOPHN Sections at the Biennial

BOARD AND COMMITTEE MEMBERS

CITIZEN COMMITTEES in health departments, the role of the voluntary nursing agency in community health programs, the board of directors in a voluntary agency, cooperative planning between a community chest and a visiting nurse association in interpreting visiting nurse service—all these were subjects of meetings arranged by the NOPHN Board and Committee Members Section at the Biennial Nursing Convention at Atlantic City in September. More than 500 board and committee members, representing 22 states and the District of Columbia, attended these and other convention sessions.

To the question "Does a Health Department Need a Citizens' Committee for the Nursing Division?" all five participants in a panel discussion answered yes. Participants were: Mrs. C. S. Duvall, Jr., and Mrs. J. A. Watson, Jr., members of the Public Health Lay Council, Montgomery County Health Department, Maryland; V. L. Ellicott, M.D., county health officer, Montgomery County Health Department, Maryland; Ruby Wallace, R.N., supervising nurse, Bedford-Marshall District Health Department, Shelbyville, Tennessee; and John M. Whitney, M.D., superintendent of health, New Orleans City Health Department, Louisiana. Mildred Tuttle, R.N., nursing director, W. K. Kellogg Foundation, Battle Creek, Michigan, presided. A citizens committee, it was felt, could carry out at least nine major functions: (1) advise health departments on policies and programs (2) represent the layman's and consumer's points of views—especially as to service (3) participate in selected service activities (4) interpret the needs of the community to the health department and the services of the health department to the community (5) disseminate accurate information to the community about what is being done and what needs to be done (6) pool judgments of laymen on matters pertaining to public health (7) seek counsel and information from health department personnel (8) identify problems for study and develop with the health department an "active plan" based on discovered needs (9) provide stability to health department programs by creating favorable public opinion and action in relation to budget appropriations from tax funds for public health service.

Paying tribute to members of boards of directors of voluntary agencies, Dr. C.-E. A. Winslow pointed out that these boards have a grave responsibility and can exert a powerful influence in securing good health departments, facilities for chronic and convalescent care and the other background essentials of the public health program. Dr. Winslow spoke at a luncheon meeting attended by 300 members of boards of directors of visiting nurse associations and schools of nursing. (The full text of his speech appeared in PUBLIC HEALTH NURSING, November 1946.)

Ways of achieving a board of directors that is truly representative of the community it serves, the importance of special training and study programs for board members, how the board of a combination agency functions, labor's point of view about representation on boards of directors—these were the subjects presented at a symposium about "The Board of the Future." Speakers were: Mrs. Natalie W. Linderholm, consultant on agency policies, Greater New York Fund, Inc.; Wilbur F. Maxwell, director, Labor-Employee Participation Department, Community Chests and Councils, Inc.; Mrs. John G. Mulder, president, Bureau of Public Health Nursing, Montclair, New Jersey; Mrs. George T. Bell, Wilkes-Barre, Pennsylvania. Mrs. Walter G. Farr, member of the Citizens Health Council of New Jersey, presided. (The comments by Mr. Maxwell and Mrs. Mulder appear in full in this issue.)

Interpretation of an agency's service is the responsibility of the agency and not the community chest was the conclusion of both speakers at a meeting about "Interpretation of an Agency's Service—Whose Responsibility?" Speakers were: Bent Taylor, director of pub-

lic relations. Community Chests and Councils, Inc., and Willem Wirtz, of Campbell-Wirtz Associates, Public Relations Counsel, of Philadelphia and New York City. Mr. Wirtz and Mr. Taylor also recommended that chest and agency work more closely together in planning and carrying out a program of interpretation.

At the brief session held November 25, reports were made for the following committees: Know Your Public Health Nurse Week Committee by Mrs. Langdon T. Thaxter of Portland, Maine; Uniform Committee by Mrs. Philip Eiseman, Cambridge, Massachusetts; Nominating Committee by Mrs. F. S. Dellenbaugh, Jr., Litchfield, Connecticut.

Mrs. Charles E. Rolfe of Hamden, Connecticut, was elected chairman of the Executive Committee of the Section, succeeding Mrs. S. Emlen Stokes of Moorestown, New Jersey. Active in health and community affairs in New Haven and Connecticut, Mrs. Rolfe is also vice-president of the New Haven Visiting Nurse Association. Mrs. Carl B. Grawn, of Grosse Pointe, Michigan, a former president of the Visiting Nurse Association of Detroit and now a member of their Board of Directors, was elected vice-chairman.

Including the newly elected members the Executive Committee of the Section is now as follows:

Chairman—Mrs. Charles E. Rolfe
Vice-chairman—Mrs. Carl B. Grawn

New members of the Executive Committee for 1946-1950

Mrs. Dexter M. Bullard, Rockville, Maryland
Mrs. Francis L. Christy, Brooklyn, New York
Mrs. Ray E. Fuller, Des Moines, Iowa
Mrs. Mildred Hatton, R.N., Providence, Rhode Island
Mrs. Alfred G. Kay, Palm Beach, Florida, and Chester, New Jersey
Alice G. Peake, R.N., Waterbury, Connecticut
Elsa M. Peterson, Washington, D.C.
Mrs. Benjamin H. Riggs, Portland, Maine
Mrs. Philip A. Salmon, Short Hills, New Jersey

Members of the Executive Committee for 1944 to 1948:

Mrs. H. Edward Bilkey, New York, N. Y.
Mrs. Lloyd D. Brace, Charles River, Massachusetts
Mrs. Warren Buckley, Evanston, Illinois
Helene B. Buker, R.N., Lansing, Michigan
Mrs. Philip Eiseman, Cambridge, Massachusetts
Mrs. Theodor Oxhold, Esopus-on-the-Hudson and New York, N. Y.
Olivia T. Peterson, R.N., Washington, D.C.

SCHOOL NURSING

On September 23, Fern Goulding, vice chairman, opened the meeting with the announcement that Alfhild Axelsen, section chairman, and Dr. Gertrude Hildreth, consulting psychologist, who was to speak on "What is new in child development," were absent. Later word described the adventures of Miss Axelsen and Dr. Hildreth who, traveling from New York, had missed train and plane connections and then had secured a taxi which broke down half way of the 30 miles to Atlantic City! Miss Gou'ding read Miss Axelsen's report of the Section during the 1944-1946 biennial period. (See *Phn: News Bulletin*, September 1946.) Dr. Gilbreth's paper will be published in a spring issue of Public Health Nursing.

Lula P. Dilworth, chairman of the Committee on Qualifications of the Nurse in the School, gave a progress report. This countrywide committee believes the nurse in the school health program needs preparation in addition to that now included in the program of study in public health nursing. It is suggested she have also courses in school organization and administration, nursing in the school health program, child guidance, child growth and development, principles and methods of teaching, and two months of field experience in a school situation which provides supervision by a qualified school nurse.

Many individuals among the 300 present participated in the lively discussion which followed and raised many questions. How can we interest boards of education in employing nurses with adequate preparation? How can we get workshops and institutes for school nurses during summer vacations? How can we educate ourselves as nurses not to accept positions for which we are not adequately prepared? After some discussion as to whether the nurse in a school situation is a nurse or a teacher, Mary Ella Chayer commented that we as a professional group must place our main

emphasis on total nursing rather than upon the specialized fields. We must think of personnel policies in relation to all nurses and in relation to the entire community program. The great need is for nurses to get together. If we really want community nursing service, the problem isn't what agencies hire nurses, but rather their number in the community—in hospitals, industry, homes, or schools—and how their services are coordinated to serve the family group. We must investigate further what the school nurse can contribute to family service. The question of who employs the nurse is not as important at the present time as the employer's concept of family service.

The Section unanimously adopted a resolution recognizing the increased interest in the health of the school age child and the inadequacy of health services for this group, and the need for joint planning among national, state, and community agencies for more effective school health programs. (See PUBLIC HEALTH NURSING, November 1946, p. 576.)

Margaret Taylor, chairman of the Nominating Committee, read the tabulated results of the voting. Elected to the Nominating Committee for the 1946-1948 biennial period were Alfhild Axelsen, R.N., school nurse, Horace Mann-Lincoln School, New York City; John Bracken, superintendent of schools, Clayton, Missouri; and Ferne D. Hood, R.N., consultant to school nurses, Los Angeles County Schools.

Including newly elected members, the Executive Committee for the next biennial period is as follows:

Chairman—A. Mary Ross, R.N., Supervisor of School Nursing, Board of Education, Kansas City, Missouri.

Vice chairman—Bosse R. Randle, R.N., Director, Division of Public Health Nursing, Nassau County Health Department, Mineola, N. Y.

Directors for 1946-1950

Kathleen Leahy, R.N., Assistant Professor, School of Nursing Education, University of Washington, Seattle, Washington.

Adeline Chase, R.N., Assistant Professor of Public Health Nursing, University of Pennsylvania, Philadelphia, Pa.

Directors for 1944-1948

Helen Fisher, R.N., Supervisor of Nurses, Bureau of Health, Portland, Oregon.

Mellie F. Palmer, R.N., Director, Community Health Service, Minneapolis, Minn.

Dorothy Nyswander, Ph.D., School of Public Health, University of California, Berkeley, California.

I. P. Barrett, M.D., Director, School Health Service, Fort Worth, Texas.

NURSE MIDWIFERY

THE MEETING of the Nurse Midwifery Section on September 23, 1946 was one for the record. Organized in November 1945, its constitution and by laws adopted and an Executive Committee *pro tem* appointed early in 1946, the Section held the first meeting in its history at the Atlantic City Biennial. Some 250 persons attended—striking evidence of the great interest which nurses and other public health workers hold for this important specialty.

Several actions were taken at the brief business meeting which preceded the symposium of distinguished speakers. Approval was given to the resolution urging the establishment of courses in advanced maternity nursing for the further preparation of nurses to enable them to provide leadership to develop, in cooperation with other professional groups, service which goes beyond the detection and prevention of pathology and aims to bring good health to all mothers and their babies. (See PUBLIC HEALTH NURSING, November 1946, p. 576.)

An important revision of the Section's by-laws was made by which membership in the Section was opened to all NOPHN members and not only to certified nurse midwives. A concerted effort for membership in the Section will be made during the coming year. To achieve the goal of safe care and abundant health for every mother and baby, the Section believes, will demand the joint planning and effort not only of nurse midwives and other nurses but of the whole American community as well.

Progress reports were made on the work of the Section's three subcommittees: (1) subcommittee to study and evaluate standards for schools of midwifery (2) subcommittee to study and set standards for practice of midwifery and (3) subcommittee to study and promote new opportunities in the field of midwifery. The reports of these committees will be reviewed and analyzed by the Executive Committee and the findings published early in the coming year.

Helen L. Fisk, R.N., chief of the division of Public Health Nursing, Maryland State Department of Health, was elected chairman for the 1946-1950 period and Hattie Hemschemeyer, Maternity Center Association of New York, vice chairman. A complete list of the New Executive Committee is given below.

A symposium on advanced maternity nursing followed the business meeting. Those participating were Nicholson J. Eastman, M.D., Hattie Hemschemeyer, Hortense Hilbert, Kate Hyder, Ruth Lindberg, Sister M. Theophane Shoemaker, and John L. Parks, M.D. (See pages 641 and 644 for the papers by Dr. Eastman and Sister Theophane. Others in the symposium will be carried, at least in part, in the January issue of the Magazine.)

Miss Hemschemeyer prefaced her introduction of the speakers by outlining problems—the need for leadership and service in obstetric nursing programs, for community understanding, for agreement on terminology, for well marked goals for future achievements, and concluded, "The time is now to plan a future in professional nursing for the clinical specialist in obstetrics." Speakers expressed many points of view. Dr. Eastman was concerned with the designation "midwife" which, not carrying with it the same feeling of respect that it does in certain foreign countries, he feels should be supplanted by the term "advanced maternity nurse." The advanced maternity nurse, he believes, could make her greatest contribution as an organizer and a teacher, giving a broader and more highly skilled service than strict midwifery. In any case, our ultimate goal should be the delivery of all women in hospitals by obstetrical specialists. Sister Theophane pointed out that hospitals and other organized facilities for proper maternity care are still not available to a large percentage of mothers in many parts of the United States. She said a place exists in these communities for the well selected, well prepared nurse-midwife, working under a program of balanced responsibility with the physicians of the community. Miss Lindberg and Miss Hyder, representing nursing education, emphasized the necessity of both student nurses and graduate nurses in advanced maternity courses having the opportunity to participate in the care of maternity patients throughout the course of pregnancy, at delivery and during the puerperium. All speakers stressed the importance of mental hygiene in pregnancy and education of the mother and family. These facets of maternity care have long been neglected. They are peculiarly the functions of the nurse for which she should be well prepared and of which she should be ever conscious. Dr. Parks summed up the discussion.

The officers and directors comprising the Executive Committee of the Nurse Midwifery Section are:

Chairman—Helen L. Fisk, R.N.
Vice chairman—Hattie Hemschemeyer, R.N.

For the term 1946-1950:

Sara E. Fetter, R.N., Public Health Nursing Consultant in Maternity, Maryland State Dept. of Health
Mrs. Catherine Lory, R.N., State Board of Health, Columbus, Indiana
Mrs. Frances D. Sell, Senior Advisor, School of Nurse-Midwifery, Maternity Center Association, New York, N. Y.
Sister M. Theophane Shoemaker, R.N., Director, Santa Fe Catholic Maternity Center and Institute of Midwifery

For the term 1946-1948:

Hazel Corbin, R.N., Director, Maternity Center Association of New York
Nicholson J. Eastman, M.D., Professor of Obstetrics, Johns Hopkins University
George W. Kosmak, Editor, *American Journal of Obstetrics and Gynecology,* New York, N. Y.
Lucile Petry, R.N., Director, Division of Nurse Education, USPHS, Washington, D.C. (Alternate: Mary Dunn, R.N., USPHS)
R. H. Riley, M.D., Director, Maryland State Department of Health, Baltimore, Md.
Ruth G. Taylor, R.N., Director, Nursing Division, Children's Bureau, Washington, D.C. (Alternate: Ruth Doran, R.N., Children's Bureau)

INDUSTRIAL NURSING

THE Industrial Nursing Section, in cooperation with the Joint Orthopedic Nursing Advisory Service, this year sponsored the joint session on "Rehabilitation" at the Biennial, September 26. Papers were presented by a number of experts in the field of medicine and nursing, including Dr. Howard A. Rusk, Dr. David Slight, Anna Fillmore, and Margaret Ladd.

The Section's business meeting took place on September 24. Anna M. Fillmore, chairman, reviewed Section activities briefly. There have been no regular meetings of the Executive Committee since the 1944 Biennial in Buffalo, partly because of war pressures and partly because plans were made at that meeting for carrying on the work of the Section. Committee members, however, have given active assistance and support to the Section through numerous individual conferences and letters.

An important accomplishment of the Section was the publication by the Commonwealth Fund early in 1946 of "Nursing in Commerce and Industry" by Mrs. Bethel McGrath, former NOPHN industrial nursing consultant. This manual was much needed and the current large sales prove its usefulness to management, workers, physicians, nurses and other members of the community.

Another project during the past year, in answer to requests for help from many plants and agencies, was the study of part-time nursing service in small industrial establishments, under the auspices of visiting nurse associations. The study was made by the Committee on Part-Time Nursing Service to Industry, with Mrs. Eleanor Bailey as chairman, and the findings published in the 68-page report, "Part-Time Nursing Service to Industry." Lucille Harmon reported briefly for the committee. Questionnaires were sent to visiting nurse associations which had provided nursing service to industry on a part-time basis for at least one year and 25 agencies submitted comprehensive data for study. These agencies gave service on a part-time basis to only 75 plants, Miss Harmon stated, showing that only a small proportion of the total needs of nursing service in small plants is being met. Almost 50 percent of industrial workers are employed in plants of less than 250, and about 25 percent in plants of less than 100 workers. Miss Harmon summarized the major recommendations made by the committee based on the findings of the study:

1. Visiting nurse associations should extend service to small plants, especially those employing less than 250 workers, as rapidly as experienced nurses are available. If the service develops sufficiently to warrant a full-time nurse, the plant should be encouraged to take the agency nurse on its own payroll.

2. Promotion of part-time service to industrial concerns by visiting nursing associations is most effectively carried out in cooperation with other organizations in the community interested in industrial health. Therefore, VNA's should have an industrial advisory committee with representatives from these organizations and from its own board of directors to aid in planning and promoting their industrial nursing service program.

3. Plants and agencies should have a written agreement, simple, brief, and broad in scope, and supplemented by a statement of program and policies.

4. The plant should provide adequate equipment and space for the health service.

5. The minimum block of nursing time at one period, in a plant having more than 35 workers, should be two hours. The maximum time and frequency of visits depend on the need, interest of management, and the medical service available.

6. Part-time nursing service should be self-supporting, but not profit-making.

7. Records forms should be simple but adequate. They must be confidential and kept in a locked file in the medical department. The record system should be standardized for all firms served by the agency, its cost included in the fee charged the plant.

8. If part-time service to small plants is to become a part of the community service offered by public health nursing agencies, preparation in industrial nursing should be included in the basic preparation of all public health nurses. But until nurses giving such service can be selected from those who have had both theory and field experience in industrial nursing, it is necessary to plan for them a more extensive and individualized orientation than is usual for nurses in other special

services. The general supervisor, her assistant, and others on the staff, also, should have a thorough understanding of industrial nursing and health needs because of their responsibilities for the agency's industrial program.

Another problem brought before the meeting for discussion was the tendency of both nurses and physicians to over-rely on standing orders. In many cases nurses are depending upon standing orders which permit them to perform functions which they are not prepared or licensed to perform, and which do not provide them with needed legal protection. This warning applies especially to nurses working on a part-time basis in plants where there is only a physician on call. The group agreed that the danger should be emphasized of either nurse or doctor adopting in their entirety any ready-made standing orders, without a complete understanding of the functions they specifically authorize and the legal protection they provide. It was further agreed that nurses in industry, both those on a part- and full-time basis, should be stimulated to familiarize themselves with nurse and medical practice acts in their respective states, and to discuss these with other nurses and physicians.

The following were elected to the Executive Committee of the Industrial Nursing Section for the coming biennium:

Chairman—Lucille Harmon, R.N., Industrial Nursing Consultant, Visiting Nurse Association of Detroit, Detroit, Michigan

Vice-chairman—Kathryn M. Frankenfield, R.N., Industrial Nursing Consultant, Visiting Nurse Society of Philadelphia, Philadelphia, Pennsylvania

Ethel C. Burgeson, R.N., Nursing Supervisor, Sears Roebuck and Company, Chicago, Illinois

Catherine Chambers, R.N., Industrial Nursing Consultant, State Board of Health, Madison, Wisconsin

Glenn S. Everts, M.D., Philadelphia, Pennsylvania

Charlotte Ferry, R.N., Industrial Nursing Consultant, State Department of Health, Los Angeles, Calif.

Glenn F. Griffin, Safety Engineer, National Safety Council, Chicago, Illinois

Sarah E. Marshall, Director, A.F. of L. Service Bureau, New York Labor Chest, New York, N. Y.

Charlotte M. Noble, R.N., Supervisor in Industrial Nursing, Visiting Nurse Service of Brooklyn, Brooklyn, N. Y.

William A. Sawyer, M.D., Medical Director, Eastman Kodak Company, Rochester, N. Y.

Emily Myrtle Smith, R.N., Industrial Nursing Consultant, Department of Health, Detroit, Michigan

Bernardine E. Striegel, Group Nursing Assistant, Metropolitan Life Insurance Company, New York. N. Y.

A. Wellington Taylor, Ph.D., Director of Commercial Education, Chamber of Commerce, State of New York, New York, N. Y.

TUBERCULOSIS NURSING COURSES

Courses in tuberculosis nursing to be offered at Syracuse University this spring will interest public health nurses desiring positions as supervisors and consultants in this field. These full-time courses, running from February 3 through June 1, will include lectures, demonstrations, and eight weeks of field work at the Tri Boro Hospital, New York City.

Students applying for these courses should meet high school and basic professional requirements for admission to the Syracuse University Department of Public Health Nursing and also special professional requirements, namely post graduate preparation in public health nursing and two years' experience, one under direct qualified supervision in public health nursing service in which family health is emphasized. Experience as a generalized or specialized supervisor is desirable. Credits acquired in these courses may be applied to a Bachelor of Science degree with a major in public health nursing. For application forms, write immediately to the director of the Department of Public Health Nursing, College of Medicine, Syracuse University, Syracuse, New York.

No Drug Yet for TB

(Continued from page 636)

And we should continue wholeheartedly to support the Seal Sale drives and all other movements to forward the campaign against tuberculosis. There will be plenty of time to relax in our efforts if and when a cure is actually here.

H. STUART WILLIS, M.D.
INTERIM DIRECTOR, COMMITTEE ON MEDICAL RESEARCH
NATIONAL TUBERCULOSIS ASSOCIATION

Reviews and Book Notes

KATHARINE KENT

By Mary S. Gardner. 298p. Macmillan Company, New York. 1946. $2.75.

Katharine Kent is a delightful story of a public health nurse whose outstanding career begins early in the present century. Despite the stormy periods in her professional life, Miss Kent always manages to "keep her wagon hitched to a star."

Into this fascinating story Miss Gardner has interwoven an accurate account of the development of the public health nursing movement.

Every public health nursing agency will want to add a copy of "Katharine Kent" to its library. For those already working in the field it will serve not only as a refresher but as an inspiration. Board and committee members will find the book most interesting since it demonstrates so well that concerted action is the foundation upon which a successful program is built.

For the student nurse "Katharine Kent" will afford an excellent means of becoming acquainted with the field of public health nursing through the writing of one of its most outstanding leaders.

—Marion M. Campbell, *Executive Secretary, Community Health and Civic Association, Ardmore, Pennsylvania.*

COUNSELING TECHNIQUES IN ADULT EDUCATION

By Paul E. Klein and Ruth E. Moffitt. 185p. McGraw-Hill Book Company, Inc., New York, first edition, 1946. $2.00.

This is a comprehensive presentation of guidance in the field of adult education. The authors concentrate on the school situation and naturally include much detailed material on content and method of a counseling program in that area. While some of these details may be lacking in interest to those not engaged in a school counseling program, the philosophy of the book and the practices recommended are applicable to other fields. The general theme which is injected a number of times throughout the book is that "the true heart of counseling lies in a sincere and genuine interest in the well-being and development of each man or woman with whom we have contact, in the recognition of each as an individual different from any other, and in the maintenance of a friendly, informal atmosphere with a positive and hopeful outlook."

The question as to who should do counseling is discussed objectively. The authors' attitude is that all members of the school staff,—teachers, principal, counselor, and even the office staff, make important contributions in a cooperative counseling program.

The book provides many suggestions and technics for occupational counseling which would be helpful in counseling adults in any field. The personal inventory, testing, and other methods of securing personal data are discussed at length. Sources of occupational information are given.

The book should stimulate interest in counseling and give a better understanding of the much needed service to adults that counseling programs have to offer.

—Kathryn A. Loughrey, *Supervisor of Personnel, New York City Department of Health, New York, N. Y.*

REHABILITATION: ITS PRINCIPLES AND PRACTICE

By John Eisele Davis, M.A., Sc.D. 264 p. A. S. Barnes and Company, New York 18, N. Y. Revised Edition. 1946. $3.00.

In this "revised and enlarged edition" the author approaches the problem of rehabilitation of mentally handicapped persons from all conceivable angles. The chapter headings illustrate the broad scope of this book's contents: The Psychiatric Approach, The Psychological Approach, Interest and Effort Theories, Elementary Principles of Mental, Nervous and Physical Reconstruction, et cetera. In the opinion of this reviewer, the extreme electicism of this volume is a liability rather than an asset. It is difficult to follow the

author's thinking in this conglomeration of vaguely organized material drawn from many sources. There is much that is repetitious. The reader will find himself annoyed at the tendency of the author to lean heavily on quotations of other experts, without clearly integrating these various points of view into a simple, unified philosophy of rehabilitation. Without doubt the author has read widely, but one fails to see how this extensive reading of and borrowing from authorities from many fields results finally in a unified and systematic formulation of the issues of rehabilitation. The unity of the human personality is destroyed by the author's tendency to partialize and fragment human behaviour. When an author presents many contradictory theoretical systems, one can be sure that he has no theory at all. The book is lacking in vitality; it has the dry quality of an old fashioned text on psychology. It fails conspicuously to touch the profound human aspects of rehabilitation.

—NATHAN W. ACKERMAN, M.D., *Instructor of Psychiatry, Columbia University, New York, N. Y.*

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

ALCOHOL IS A SICKNESS. By Herbert Yahraes. Public Affairs Pamphlet No. 118. Public Affairs Committee, Inc., 30 Rockefeller Plaza, New York 20, N. Y. 1946. 32 pp. Single copy: 10c.

AMERICAN LABOR UNIONS: What they are and how they work. By Florence Peterson. Harper and Brothers, New York, N. Y., 1945. $3.00.

AMERICAN MINORITY PEOPLE DURING WORLD WAR II. Basic Readings for Americans Concerned about Race Relations. By Edmonia White Grant. American Missionary Association, 287 Fourth Avenue, New York 10, N. Y. November 1945. Single copy: free; quantity orders: $3.00 per hundred.

AN APPROACH TOWARD OBJECTIVITY IN EVALUATING SOCIAL WORK PERFORMANCE. By Martha Strong Smith. *The Compass*, March 1946, page 33. American Association of Social Workers, 130 E. 22nd St., New York, N. Y. Annual subscription: $1.00 to nonmembers; special student rates: 50c.

Supervisors will find article and reference list helpful both to those in official agencies working with merit and civil service systems and to those in voluntary agencies responsible for periodic evaluation as part of total supervisory program.

APPLICATIONS OF GERMICIDAL ERYTHEMAL AND INFRARED ENERGY. By Matthew Luckiesh, D.Sc. 463p. D. Van Nostrand Company, Inc., New York, N. Y. 1946. Price: $5.50.

THE CAMP NURSE. By Elizabeth McCann. *The Canadian Nurse*. July 1946, page 557. The Canadian Nurses Association, 522 Medical Arts Building, Montreal 25, Quebec. Single copy: 25 cents.

COMMUNITY CHEST BUDGETING. Bulletin 127, June 1946. 11 pp. Community Chests and Councils, Inc., 155 E. 44th St., New York 17, N. Y. Single copy: 15c.

DIRECTORY OF PSYCHIATRIC CLINICS IN THE UNITED STATES AND OTHER RESOURCES. 1946. 78 pp. The National Committee for Mental Hygiene, Inc., 1790 Broadway, New York 19, N. Y. Single copy: 50c.

This directory includes state institutions, state governmental departments, Veterans Administration—regional offices and hospitals, mental hygiene societies, family welfare societies, community welfare councils, veterans information centers.

FOLLOWING THROUGH WITH THE POST-HOSPITAL PATIENT. By Ruth W. Hubbard, R.N. *Philadelphia Medicine*, June 15, 1946, page 1499. The Philadelphia County Medical Society, 301 S. 21st St., Philadelphia 3, Pa. Single copy: 5c.

AN INTERVIEW METHOD FOR OBTAINING PERSONAL HISTORIES. By Clark W. Heath, M.D. *The New England Journal of Medicine*, February 21, 1946, page 251. Massachusetts Medical Society, 8 Fenway, Boston 15, Mass. Single copy: 25c.

Some reprints are available. Requests should be sent to Clark W. Heath, M.D., Department of Hygiene, Harvard University, 13 Holyoke St., Cambridge 38, Mass.

NURSING EDUCATION

MICROBIOLOGY AND PATHOLOGY FOR NURSES. By Mary Elizabeth Morse, M.D. 758p. W. B. Saunders Company, Philadelphia, Pennsylvania. 2nd Edition. 1946. Price: $3.50.

PROFESSIONAL ADJUSTMENT IN NURSING. By Eugenia K. Spalding, R.N. 509p. J. B. Lippincott Company, Philadelphia, Pennsylvania. 3rd Edition. 1946. Price: $3.50.

NUTRITION

NUTRITION AND DIET THERAPY. By Fairfax T. Proudfit, and Corinne Hogden Robinson. 782p. The Macmillan Company, New York, N. Y. 9th Edition. 1946. Price: $3.75.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

BOARD MEMBERS TO MEET

NOPHN Board members will convene at the Visiting Nurse Society of New York for two days this year, January 23-24. The meeting of the Joint Boards of the American Nurses' Association, the National League of Nursing Education and the NOPHN will follow on January 25.

COUNCIL OF BRANCHES IN CHICAGO

The Council of Branches, an organization composed of state organizations for public health nursing, will hold a two-day annual meeting on December 12-13. In response to the general desire for a more centrally located meeting place, Chicago was chosen to receive the delegates. The Council, convening at the Stevens Hotel, will discuss among other subjects the Structure Study, organization and functions of SOPHN's, relationships between public health nursing agencies, hospitals, and schools of nursing in the interest of continuous care to patients, personnel policies, and public relations.

NEW STRUCTURE STUDY COMMITTEE

The final meeting of the old Structure Study Committee and the first meeting of the larger Joint Committee on the Structure of National Nursing Organizations occurred on November 20, 21 and 22, 1946, in New York City. The Joint Committee comprises 54 members, 12 from the American Nurses' Association, 6 from each of the 5 other national nursing organizations participating in the study, and the president and executive secretary of each organization as members, ex-officio.

Topics in the agenda for the meeting included organization of the committee, formation of policies and methods of procedure, plans for disseminating information about the study to all parts of the country, and consideration of means for financing the work of the committee.

The following officers were elected: Hortense Hilbert, chairman; Margaret Tracy, vice-chairman; Mrs. Estelle Massey Riddle, secretary; and Alma C. Haupt, treasurer.

Report of the treasurer for the old committee disclosed that nurses and nursing organizations have contributed in round numbers $18,000 for the structure study. The old committee was dissolved and it was voted to turn over the few hundred dollars remaining in the treasury to the new Joint Committee on the Structure of National Nursing Organizations to help with expenses of further studying the report, disseminating information about it to all members, and finally formulating recommendations and constitution and bylaws to submit to a national constitutional convention.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
NOPHN Council of Branches Meeting	Chicago, Ill.—Dec. 12, 13
Ruth Houlton	
Ruth Fisher	
Sarah A. Moore	
Eleanor Palmquist	
Edith Wensley	
Alberta B. Wilson	
Hazel Herringshaw	
Other Field Trips	
Ruth Houlton	Washington, D.C.—Dec. 9-11
Ruth Fisher	Washington, D.C.—Dec. 4-6
	Suffolk County, N. Y.—Dec. 10
	Springfield and Peoria, Ill.—Dec. 16, 17
Hedwig Cohen	Suffolk County, N. Y.—Dec. 10
Mable E Grover	Lynchburg, Va.—Dec. 2, 3
	Camden, N. J.—Dec. 16-18
Margaret P. Ladd	Washington, D.C.—Dec. 4, 5
	Chicago, Ill.—Dec. 8-12
	Pittsburgh, Pa.—Dec. 13, 14
	Minneapolis, Minn.—Dec. 26-31
Louise M. Suchomel	Bridgeport, Conn.—Dec. 2-7
Dorothy Wiesner	Minneapolis, Minn.—Dec. 2-6
	St. Paul, Minn.—Dec. 9
	Omaha, Neb.—Dec. 10-12
	St. Louis, Mo.—Dec. 13-16
Alberta B. Wilson	Kansas City, Mo.—Dec. 4-10

In November, after the magazine went to press, Ruth Houlton and Ruth Fisher visited Washington, D.C.; Hedwig Cohen and Ruth Fisher made a survey in Suffolk County, New York; and Sarah A. Moore visited Pittsfield, Worcester, and Roston, Mass.

NEWS AND VIEWS

On Nursing

NURSES OF MANY NATIONS TO CONVENE

With interest in global relationships at a high peak, nurses all over the world look forward to the Congress of the International Council of Nurses to be held at Atlantic City, New Jersey, May 11-17, 1947. The Board of Directors of the International Council, composed of I.C.N. officers and the presidents of the member national associations, met at the Royal College of Nursing in London in September for the chief purpose of planning this first Congress of the International Council since 1937, when its schedule of convening every four years was temporarily abandoned because of the war. In spite of difficult traveling conditions and other postwar obstacles, 19 member nations sent delegates.

The International Council of Nurses, founded in 1899 by Mrs. Bradford Fenwick of Great Britain, represents nurses from some 30 countries. Working through its member national associations, the Council Board, committees, and the international congresses, ICN promotes the improvement of nursing standards and the advancement of the training, professional status, and well-being of nurses throughout the world. Effie E. Taylor, retired Dean of Yale University School of Nurses, is president of the International Council. Other officers include nurses from South Africa, France, Canada and Great Britain. Election of new officers will take place at a meeting of the ICN Grand Council, just prior to the opening of the congress.

International Congress agendas usually include sessions on training and education of the nurse, hospital administration, public health nursing, industrial nursing, and many other subjects of interest. Talks by specialists, translated by nurse interpreters into the languages of countries represented, and followed by lively discussions, give those present new health ideas to take back to the nursing centers of the world.

Each member national association sends its president and four delegates to the Congress. However, any nurse who is a member of any association affiliated with International Council is eligible to attend.

BETTER HEALTH FOR LIBERIA

A thriving maternity center, described by Ellen Miama Moore in her article "'Cooked Water' for Liberia" (PUBLIC HEALTH NURSING October 1946), continues to raise the health standard of Kakata, Liberia. Under the direct medical supervision of Dr. J. B. Titus, health officer of public health and sanitation, Republic of Liberia, the Center serves both Americo-Liberians and members of the seven native tribes of the region.

A report from Miss Moore, who is the public health nurse directing the Center, tells the story of an ever broadening service on this health frontier. From April to July of this year a total of 1193 patients visited the clinic. Thirty families received home visits. Under a regular public school health program, 140 children have health supervision and hear monthly health lectures. Monthly records show a reduction of diarrhea cases of from 15 to 2 cases, dysentery from 8 cases to 1, and worms from 25 to 5. Families have learned to bring their problems to the clinic. Health rules stressed include the importance of early and safe prenatal care; the essentials of infant and child health, and diet in relation to Liberian health. Boiling of drinking water is now widely practiced.

Miss Moore's report lists needed supplies scarce at the Center. Besides cotton, gauze bandages, adhesive tape, diapers, umbilical bands and newspapers she asks for materials for little youth dresses, adding "we can sew them ourselves." Contributions of these items should be sent to Ellen M. Moore, R.N., P. O. Box 16B, Monrovia City, Liberia, W. C. A. The Center does not have to pay duty on supplies.

COLORED NURSES CONVENE

Several hundred nurses attended regional conferences of the National Association of Colored Graduate Nurses at the St. Philip Hospital and School of Nursing, Richmond, Virginia, and the Meharry Medical College, Nashville, Tennessee, in October. Subjects of discussion included the structure study of the national nursing organizations, ways of increasing enrollment in schools of nursing, major plans to meet the nation's nursing needs, and public opinion about

nursing and health on which topic representative citizens spoke. The recent action of the ANA regarding membership of Negro nurses unable join their state nursing organizations received special attention.

Both conferences adopted resolutions calling for a permanent federal fair employment practices law, federal aid to nursing education on the basic and advanced levels, federal prohibition of the poll tax and federal anti-lynching laws, federal housing aid, and a national health bill.

TRAINING-ON-THE-JOB

The Retraining and Reemployment Administration of the U. S. Department of Labor is interested in all aspects of problems facing veterans during the transitional period back to civilian life and activities. For many types of work activity, the Retraining and Reemployment Administration has evolved training-on-the-job programs. Subsistence allowances are granted the veteran to supplement training-on-the-job earnings.

Many returning nurse veterans are interested in learning whether they are entitled to subsidies from the Retraining and Reemployment Administration during the introductory period of their admission to a public health nursing agency. The NOPHN has communicated with the Veterans Administration concerning this point. According to VA interpretation, orientation to a public health nursing agency is not training-on-the-job for which compensation is to be granted by the Retraining and Reemployment Administration. Of course, for those nurse veterans who are attending university courses under the GI Bill of Rights, this bill does cover the costs of field experience which is a part of the program of study.

From Far and Near

● The Association of Collegiate Schools of Nursing at its annual meeting on September 19-20, chose new officers and board members. Among those elected are Elizabeth S. Bixler, Yale University, New Haven, Connecticut, President; Pearl Castile, University of California, Berkeley, California, Vice-President; Katherine Faville, Wayne University, Detroit, Michigan, Secretary; Agnes Gelinas, Skidmore College, New York, New York, Treasurer.

Postgraduate Course in Psychosomatics—Twenty-five general practitioners took a two-weeks experimental course in psychosomatic medicine at the Center for Continuation Study of the University of Minnesota. The course, which was sponsored by the Commonwealth Fund and the University's Division of Postgraduate Education, consisted of both lectures and clinical study. At the termination of the course these goals were defined:

1. To give the doctor a feeling of the dynamic qualities and the value of the doctor-patient relationship.
2. To introduce him to broad patterns of human motivation and to the common causes and backgrounds of emotional disturbance.
3. To lead him to think in terms of the relation between emotional disturbance and illness.
4. To teach him easily understandable methods of therapy so that he can treat a share of such illness.
5. To give him some knowledge of more malignant conditions so that he may refer them to specialists.

Patients' Information About TB—Dr. Parran has said that "[Tuberculosis control] was the first instance in which we undertook to control a disease, not by specific immunization or quarantine, but essentially by the power of public education." In the July 1946 *American Review of Tuberculosis* Dr. Joseph Newman presents interesting aspects of the educational programs used.

Since the control of the disease must start at its source, it is vitally important that each patient have an understanding of his illness. Since all education should start from what is already known and proceed according to individual needs and abilities, Dr. Newman devised a questionnaire to use with patients to ascertain what knowledge they had and how much they understood.

Dr. Newman reviews the technics employed in formulating a worthwhile questionnaire. The topics covered include: Nature and cause of tuberculosis; hygienic measures that should be observed; diagnosis and treatment; and care after discharge. The questionnaire was used on newly diagnosed patients as well as "old" patients and on control groups. The conclusions are revealing: "The results of the analysis of the answers of various groups indicate that there is no broad configuration of understanding or misunderstanding concerning tuberculosis and its treatment in the various groups sampled. Rather there is considerable individual variation." The following are the points most generally misunderstood:

1. Tuberculosis as an illness may run an erratic course.
2. The necessity for radical measures to destroy used paper tissues, such as by burning.
3. Recognition of subtle symptoms of tuberculosis.
4. Association of dramatic and traditional symptoms with all tuberculosis.
5. The significance of negative sputum in relation to progress.

The Causative Factors in Obesity—The *Physician's Bulletin* (Eli Lilly and Company) for September-October 1946 has summarized the present knowledge

concerning "obesity." Obesity which is the result of too much adipose tissue, is fairly common and always is a biological disadvantage. In the age group 45-50, there is an increase of about 1 percent in mortality for each pound of additional weight.

Obesity results when the caloric intake is greater than the energy output. Obesity has been found in relation to hypothyroidism, hypopituitarism, and hypogonadism. Is obesity when found in these conditions due to the endocrine disturbance or is there another relationship? Review of literature indicates strongly that obesity found in relationship to endocrine disturbances is in general due to reduction in energy without adequate reduction to total calorie intake. Endocrine diseases should have proper treatment but this should not be counted upon for weight reduction. Will power which leads to the ingestion of fewer calories is the only valid reducing agent.

Instructing Parents About Enuresis—A method of helping parents understand their child's enuresis is presented by Dr. Clifford Sweet in the October 5, 1946 *Journal of the American Medical Association*. Although parents take incontinent children to physicians for treatment, states Dr. Sweet, therapy must start with the education of the adults. Parents too often are confused by their own emotional responses of resentment, shame and fear. And unfortunately they have not learned that voluntary control of urination during sleep comes at a later age than during waking hours.

Of course, in every case of child enuresis the possibility of infection and of anatomic abnormalities of the urinary system must first be ruled out. Then the troubled parent is told that no child should be accused of enuresis until he is well beyond the age when he can control micturition even when asleep.

It is recognized that bladder (and bowel) control passes through three stages: The first stage is largely reflex. The infant urinates about every 15 minutes. He cannot be kept dry. The second stage lasts through the first year or a little longer, and during this period the baby does not yet have conscious control, although he is more aware of the act of urinating. The child may even learn to release the sphincters in this stage when he is placed on the toilet seat, so that he appears to be "toilet-trained." Indeed this ability may develop months before the child can voluntarily inhibit their release. The mother may put him on the toilet to "catch" him and save herself a change of his diapers, but she is not training him. The only contribution made to training by keeping the child clean is that he gradually learns to prefer it to being unclean. The third stage is the gradual conscious control of the act of urination. It requires self-imposed discipline and can be achieved only when the child has grown psychologically and physically to the point of exercising self-control. The average age for the child to begin to assume this responsibility is about 23 months.

Enuresis (excluding that due to a physical cause) which continues beyond a seemingly normal period is most probably due to one of three psychologic reasons or a combination of these. The child, regardless of other development, may not have matured in this one function. Subconsciously the child may desire to remain on an infantile level and not accept the responsibilities of this age. The child may be expressing a subconscious resentment against parental control.

The medical and surgical approach to this problem seldom solves it and too great dependence upon these procedures may cause the habit to continue late into childhood or even into adult life. That enuresis is essentially a psychosomatic problem is borne out by the fact that girls rarely continue it after the menses are well established; and members of both sexes often discontinue enuresis overnight just before they marry.

Penicillin Therapy of Syphilis Today—Although the exact status of penicillin therapy in syphilis is still unknown, several positive deductions can be made, report P. A. O'Leary, M.D. and R. R. Kierland, M.D. in the *Journal of the American Medical Association*, October 26, 1946. Its advantages are, according to these authorities, penicillin produces few reactions and it can be given in a short period of time with minimal technical difficulties and eventually at less cost than chemo-therapy. Its disadvantages are: hospitalization for a week or ten days is required and injections given at two or three hour intervals. Penicillin in beeswax and peanut oil may overcome these objections.

In early syphilis results from penicillin are inferior to those from five day drip or multiple daily injections with syringe of arsenoxide. However, complications from the latter two procedures are frequent and serious. Penicillin in combination with oxophenarsine hydrochloride and a bismuth preparation given before or after or concurrently is at this time the most successful treatment of early syphilis. The shorter the duration of the syphilis the better the results.

In late cutaneous, osseus and gastric syphilis and early hepatic syphilis, results from penicillin are excellent, but in latent and cardiovascular disease insufficient evidence is available upon which to judge. In neurosyphilis the meningeal types of disease respond well but the parenchymatous forms are more resistant to penicillin. After penicillin serologic reversals are more satisfactory than clinical improvements. Penicillin and malarial therapy produce more serologic and clinical improvement than fever therapy alone or penicillin alone.

The single outstanding value of penicillin is observed in the treatment of pregnant syphilitic women. It seldom fails to prevent syphilis in the offspring. In congenital syphilis results are variable. Many more patients must be treated and observed before the value of penicillin with this group can be estimated.

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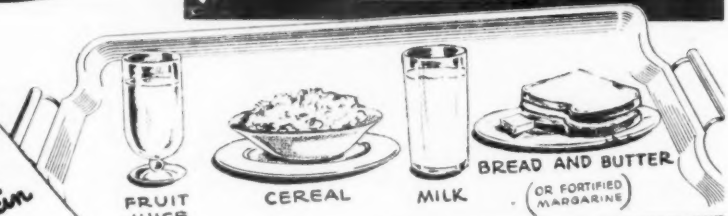

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% OF ADULT MINIMUM DAILY NEEDS	9%**	18%	7%	19%	3.8%**

(199 CALORIES)

* POST'S CORN TOASTIES (1 OZ), MILK (4 OZ), SUGAR (1 TSP.)
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Simply place granule on mirror and flow 2-3 drops of specimen over granule. Faint turbidity, after 10 sec. indicates approx. 10 mg albumin per ml. Larger percentages yield correspondingly heavier precipitates.

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F. O. B. New York

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Some of BABEE-TENDA advantages over high chairs

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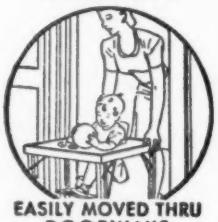

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Beginning January 1947 charges for classified advertising in PUBLIC HEALTH NURSING will be: single insertions free to agency members up to 50 words. Charges to non-member agencies, 10c per word, minimum of $3.00 for 30 words or less. Payment shoul daccompany copy.

WANTED—immediately, three Public Health Nurses in resort area of Southeastern Michigan. Newly established Health Department with supervising nurse. Salary range $2100-2500 per year, plus mileage. Contact Doctor H. C. Huntley, Director, Lenawee County Health Department, Adrian, Michigan.

WANTED—Public Health Nurse. To act as supervising nurse as public health program is built up. Salary to start, $2400. Month's vacation and twelve days' sick leave annually. Car provided. Apply: Mifflin County Red Cross Chapter, Lewiston, Pennsylvania.

WANTED—Staff Nurses (several) in VNA generalized program—Salary $1800 to $2400 yearly depending on qualifications.

HEALTH EDUCATION DIRECTOR—College degree, Car essential—Salary open—apply Director Atlantic Visiting Nurse and Tuberculosis Association, 2332 Pacific Avenue, Atlantic City, New Jersey.

WANTED—Nurses for staff positions in generalized public health nursing program located in suburban area adjacent to Washington, D. C. Minimum salary $2400 per year. Must own car. Opportunity for attending part-time universities in Washington, D. C. Reply Director Nursing Bureau, Arlington County Health Department, Arlington, Virginia.

WANTED—well-qualified public health nurse with experience, in a joint three-county service. Salary $240 per month. Liberal car allowance. Write Division of Public Health Nursing, Oregon State Board of Health, 1022 S. W. 11th Avenue, Portland 5, Oregon.

WANTED—Public Health Nurses for staff positions on Visiting Nurse staff. Salary range, $1800-2280, depending upon experience and education. Generalized bedside nursing program five day, forty hour week. Write Director Visiting Nurse Association, 1308 Delaware Avenue, Wilmington 19, Delaware.

WANTED—Public Health Nurse Supervisor of 5-nurse organization for community of 27,000, located in Hamden, Conn., 8 miles from New Haven. Qualifications: Public Health nursing course; supervisory training. Salary up to $3500.00 dependent on qualifications. For further information write Mrs. Nathan H. White, Chairman, Hamden P.H.&V.N.A., Hamden, Conn.

WANTED—2 Public Health Nurses for southern and central Monterey County. Generalized program, no bedside care. Must own car. Salary starts at $215 plus 7c per mile for use of car. Write: Kenneth Sheriff, M.D., Box 1611, Salinas, California.

WANTED—Qualified Public Health Nurse with tuberculosis experience wanted by progressive voluntary agency with active community program.

WANTED—Supervisor for rapidly growing Visiting Nurse Service. Must have approved course in public health nursing. Salary dependent upon qualifications. Liberal car allowance. Opportunity for advancement. Unusually pleasant working conditions and even climate. Apply Director, Visiting Nurse Association, 980 Main St., Jacksonville 2, Fla.

WANTED—Director of Nurses for the Child Welfare Association, Danville, Illinois. Hours: 9 to 4 week days; Saturday afternoon, Sunday and holi days off. Car provided, month vacation with pay. Apply: Mrs. Lucille Marlatt, 1116 N. Logan Avenue, Danville, Illinois.

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Part-Time Nursing in Industry

Developing public health nursing service to reach the entire community is one of public health nursing's greatest opportunities and obligations. Especially important is the development of nursing service for small industrial plants, for almost one-half of all industrial workers in the United States are employed in plants with 250 or fewer employees.

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Demand for this booklet has been extensive, but copies are still available.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING
1790 Broadway, New York 19, N. Y.

I enclose $_____ for _____ copies of "Part-Time Nursing in Industry" (75 cents a copy)

I also enclose $_____ for _____ copies of "Personnel Policies for Public Health Nursing Agencies" (75 cents a copy) which is another recent publication of NOPHN.

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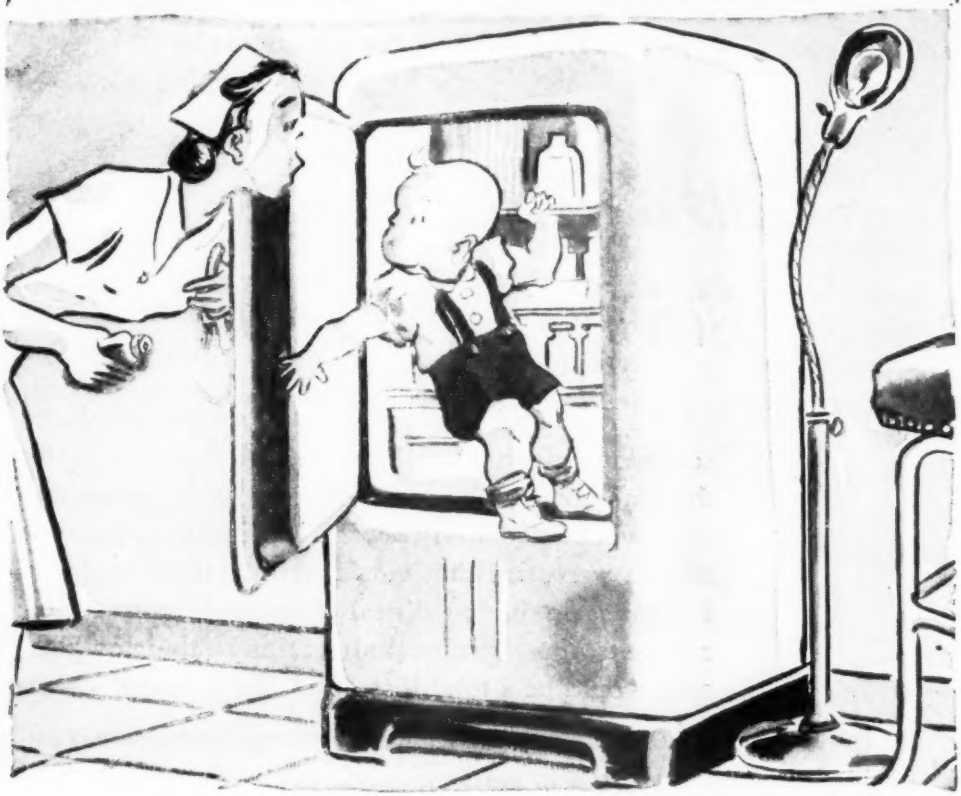

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Public Health Nursing

INDEX

Volume 38

Year 1946

OFFICIAL ORGAN

OF THE

National Organization for Public Health Nursing, Inc.

1790 Broadway, New York 19, N. Y.

INDEX

The following abbreviations are used in this index:

(abs.) abstract
(book rev.) book reviewer
(ed.) editorial
(exc.) excerpt
(n) news note
(rev.) book review

INDEX

C

INDEX

F

INDEX

I

INDEX

INDEX

INDEX

O

P

INDEX

S

INDEX

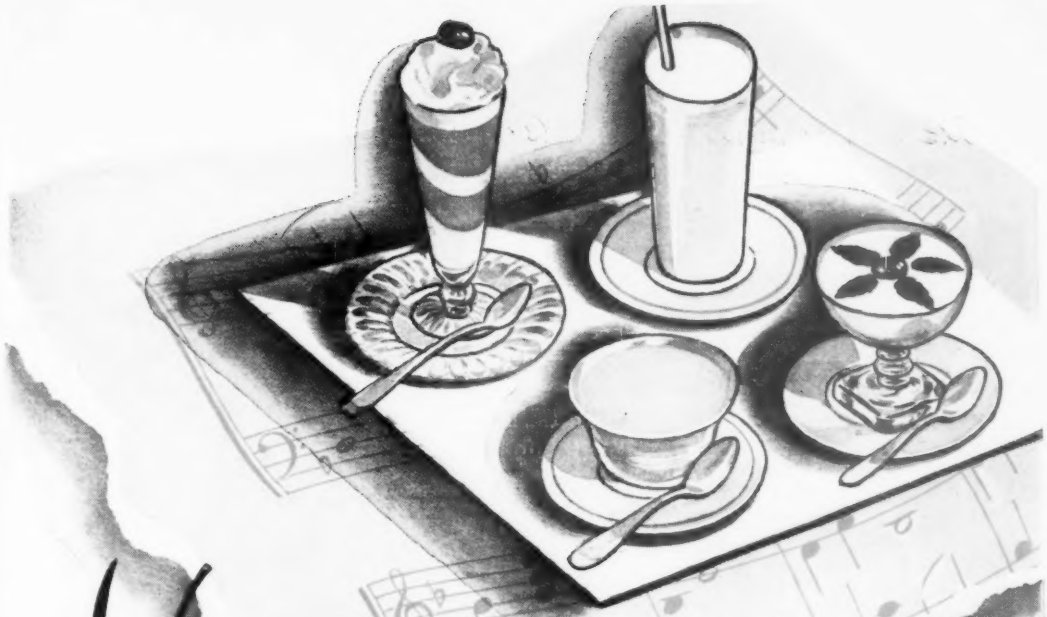
T

INDEX

W

Y

Z



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